`Counsellors' perceptions of client progression when working with clients who intentionally self-injure and the impact such work has on the therapist'.

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Abstract

Over thirty years ago the issue of intentional self-harm was viewed as exceptionally challenging for practitioners providing care for clients who engaged in this behaviour and today counsellors continue to struggle with this complex phenomenon. This study explores counsellors' perceptions of client progression when working with clients who intentionally self-injure and the impact such work has on the therapist. This qualitative phenomenological research study employed semi-structured interviews and utilised the constant comparative method to analyse the data. Findings indicate that counsellors experience intense emotions in response to clients intentional self-injury, including shock, sadness, anxiety, anger and frustration. Although participants indicated there was a requirement to work in a client-centred way, they all had either an explicit or implicit agenda for change to stop this behaviour. Participants also struggled to manage the tensions between the multiple dualities relating to the complexity of the phenomenon and the ambiguous nature of the counselling process. In addition there were various views of client progression yet all participants stated that progression was not simply about stopping the self-harm. The shocking and visible consequences of self-injury and the ambiguity relating to the counselling process, combined with the additional necessary requirements of the counsellor to provide effective therapy, exacerbates therapist anxiety. It is suggested that further research especially within the counselling field, focusing on the ambiguous nature of the issue may enlighten understanding with regards to the complexity of the subject which may help to reduce therapist anxiety by communicating the message that there is more than one way of conceiving and working with the issue of intentional self-harm.

Declaration

"The work is original and has not been submitted previously in support of any qualification or course".

Signed: .....

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Contents

List of abbreviations

A & E – Accident and Emergency

APA – American Psychiatric Association

CBT – Cognitive Behavioural Therapy

ECT – Electro-convulsive therapy

NHS – National Health Service

NICE – National Institute for Health and Clinical Excellence

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Introduction and Rationale

The issue of intentional self-harm is exceptionally challenging for practitioners. One client (Anne) who regularly self-injures describes her difficulties as:

> *"A prisoner behind invisible bars*
> *Filled deep with emotional scars*
> *Trapped forever by my mind*
> *Peace within I cannot find*". (Gardner, 2001, p143)

The purpose of this qualitative research study was to explore counsellors' experiences when working with clients who intentionally self-injure. In particular, I investigated therapists' perceptions of client progression and the impact such work has on them. Throughout the literature the terms 'self-injury' and 'self-harm' are commonly used and I will use these terms interchangeably within this dissertation. With regard to a definition of intentional self-harm there is no agreement on this within the literature, and the variety of professions contributing to theoretical understanding (Turp, 1999) appears to add to the ambiguity of opinion on the subject. One definition provided by Walsh (2008) states, "self-injury is intentional, self-effected, low-lethality bodily harm of a socially unacceptable nature, performed to reduce psychological distress" (p4). In comparison, Turp (2003) describes self-harm using a continuum model, the scale ranging from good self-care to deliberate severe self-harm. Turp's understanding, including behaviour such as smoking and excessive over-working on the continuum, is challenged by other theorists. For example, Brumberg (2006) and Woldorf (2005) would not include any culturally

sanctioned behaviour in any definition, perceiving this as distinct from the issue of intentional self-harm.

"Self-harm is a multi-professional issue" (Turp, 1999, p307) and in terms of existing literature there are a range of articles written by researchers in professions such as psychiatry, psychology, nursing and education yet comparatively less published by researchers in the counselling profession. Therefore I believed there was a real need for this present study which I hoped would provide an additional perspective. Turp (1999), who is a psychotherapist, suggests there is a paucity of literature focusing on what she describes as the 'sub-clinical population' referring to those people who self-harm who live a seemingly 'normal' life and who are not engaged in psychiatric services. She discusses how most of the published research has focused on people who self-injure when residing in institutional and medical settings like the prison services or the psychiatric services.

In the present study the link between the two aspects of client progression and the impact on the counsellor is based on the rationale that historically (prior to 1990), societal and professional expectations of client progression seemed to be focused on control and stopping the self-harm (Scott, Nelson and Gruenbaum, 1971; Feldman 1988; Favazza, 1989), and many professionals today (Pitman and Tyrer, 2008) still appear to have this goal in mind. However, there is increasing contemporary recognition (Spandler and Warner, 2007) that self-injury can often be a legitimate coping mechanism employed by clients where there is an absence of an underlying mental health condition.

Another possible alternative to these two stances may be that some counsellors could view the goal of stopping the self-harm and it being a legitimate coping mechanism as not necessarily mutually exclusive. Here there may be some acceptance that this behaviour is how the client is managing their psychological or emotional pain for now. However to guide them how to do less damage without having the goal of stopping, may feel like collusion. In this instance, my interest for this study lay in how these two aspects of it being a coping mechanism and having the goal of stopping could marry together in the process.

It is likely that whatever the view, there could be varying expectations tied to these contrasting stances thus having different connotations for the counsellor when working with clients who self-injure. Before carrying out my research my hunch was that no matter what stance a counsellor may take, there would likely be tensions between respecting and acknowledging a client's right to self-injure and acting in the best interest of the client in terms of 'healing' and moving towards stopping the self-injury: linking to a potential conflict between the ethical principles of 'Autonomy' and 'Beneficence' outlined in the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice (2009).

I also considered it a possibility that the counsellor may experience some anxiety, in terms of either not being successful in enabling the client to stop the self-harm, stemming from their own expectations or those of the wider professional community,

or feeling a failure in terms of somehow failing the client by not respecting their autonomy when the client uses self-injury as a coping mechanism.

My rationale for this study is not solely based on my counselling experience but also on my wider reading concerning clients who intentionally self-harm. Self-injury is a particularly challenging issue for any counsellor working in the field and managing client issues such as resistance to change, self-blame, self-punishment and severe self-harm can all contribute to the counsellor experiencing stress. My hunch was that such stress may be exacerbated by attempting to choose the 'right' approach and with such conflicting expectations of what that approach should be may add to the pressure. If the counsellor experiences stress over a period of time then it may make them vulnerable to burnout (Rothschild, 2006).

Over the last seven years I have worked in various settings with clients who intentionally self-harm. Although the clients I have worked with have engaged in a range of self-injury behaviour including cutting, burning, eating disorders and substance misuse, in order to gain sufficient focus I restricted this study to work with clients who self-harm by cutting and/or burning. Although at times this counselling experience has raised some difficult personal and professional issues for me, my interest lies in exploring the perceptions of other counsellors working in this field. I aimed to 'bracket off' (Willig, 2008) my former knowledge and experience as far as possible so as to fully hear the participants' views and avoid bias during data collection and analysis. My hope was that this research which is about counsellors' perceptions, would give the small number taking part an opportunity to share their

experience of working in such a challenging field and therefore enable them to take part in the 'research conversation' (McLeod, 1994) which may have some bearing on developing knowledge within the counselling profession.

My aim in engaging with this phenomenological interview based study which was an emergent design was to attain authentic accounts of the participants' experience relating to counselling clients who intentionally self-injure. To analyse the data obtained, I employed the Constant Comparative Method of analysis (Glaser and Strauss, 1967). I believed this study, focusing on counsellors' perceptions, may offer an additional perspective to the existing literature on self-harm. The majority of published research on the phenomenon has occurred within the medical professions such as psychiatry, psychology and nursing emphasizing more directive interventions and I believed a counselling perspective may give new insight in terms of understanding the subject and how best to help the person engaging in this behaviour.

Literature Review.

Search Strategy

My search strategy for this study involved me referring to literature published in research journals and academic books on intentional self-harm. I predominantly referred to research articles accessed electronically. The electronic databases and search terms are recorded below:

Databases:

- PsycARTICLES
- Psyc-INFO
- Ingenta Connect
- Info TracWeb
- Wiley InterScience

Search terms:

- Couns* and (self-harm or self-injury)
- Couns* and self-mutilation
- Psychotherapy and (self-harm or self-injury)
- Psycotherapy and self-mutilation
- Self-harm and counselling and impact
- Self-harm and self-injury and interventions
- Intentional and self-harm
- Intentional and self-injury
- Deliberate and self-harm
- Deliberate and self-injury
- Deliberate and self-mutilation
- Self-harm and recovery
- Self-mutilation and recovery

(Additional terms of 'progression' and 'impact' and 'self-injury and recovery' did not yield any specific results).

Publications searched dated from 1970 to present day (2010) aiming to attain research articles giving a historical perspective leading to a more contemporary one. In terms of client progression and the impact on the counsellor when working with clients who intentionally self-harm, I was unable to locate any specific research focusing solely on these aspects but some research had useful information in these areas, in addition to their specific research focus. For a complete breakdown of my literature search strategy please refer to Appendix 2, p94.

Historical and current relevance

During the 1960's and moving into the 1980's, the dominant view of working with self-injury was to diagnose and pathologise the person engaging in this behaviour. Therefore, due to self-injury being viewed as a chronic condition, the assumption was that it needed intensive treatment and hospitalisation (Graff & Mallin, 1967). Research by Favazza and Conterio (1988) linked mild to moderate self-harm with psychopathology such as personality disorders, multiple personality disorder and compulsive disorders. A year later, Favazza (1989) argued that the clinical diagnosis of people who intentionally self-harm was incomplete. He argued that other disorders such as 'organic mental disorder, schizophrenia, major depression, mania, obsessive compulsive disorder, hypochondrias and anti-social personality disorders' (p137) should be added to the list produced by DSM-111-R (American Psychiatric Association (APA) 1980) stating borderline personality disorder amongst others when identifying those who self-harm.

Nine years after Favazza's study, Sansone, Wiedermand and Sansone (1998) were consistent in supporting the view that intentional self-injury was linked to underlying pathology and stated self-harm being "highly related to borderline personality disorder" (p973). Klonsky (2007) acknowledges this focus linking intentional self-harm to mental health, arguing that historically self-harm was considered to be a severe manifestation of a mental health disorder. Further literature taking this view is provided by Olfson, Gameroff, Marcus, Greenber and Shaffer (2005) who found that patients admitted to community hospitals with intentional self-harm had severe psychiatric diagnoses.

From the early years of the 1960's the status of self-harm had not changed as in DSM-IV-TR (APA, 2000) it is still regarded as a symptom of Borderline Personality Disorder. However, although, many professionals today still associate this behaviour with other mental health disorders (Ross & Heath, 2002; White Kress, 2003; Walsh, 2006) there seems to be some acknowledgment that intentional self-harm can occur in "non-clinical and high-functioning populations" (Klonsky, 2007, p1040), questioning this assumption that it is predominantly linked to underlying psychopathology. Shapiro (2008) acknowledges both sides of the argument stating how intentional self-harm is "not a new phenomenon and is often associated with concurrent mental health concerns" (p124) but also suggests how there is a growing occurrence of self-injury amongst adolescents where there are no underlying mental health issues.

Even in the past there were contradictory arguments attempting to understand this complex behaviour. Although Favazza linked intentional self-mutilation with an underlying mental disorder (1988), he also described it as a 'morbid act of self-help'(1989), thus the behaviour being viewed as a kind of maladaptive coping mechanism. However there appears to be no literature at that time which took the view of it being a legitimate coping method. Although 50 years earlier Meninger (1938) understood self-harm as "an attempt at self-healing" (p671), the general historical view was that it was considered to be maladaptive in nature. In fact, Scott, Nelson and Grunebaum (1971), working from a medical model perspective, argued that "Psychotic wrist-slashers should be hospitalized with stringent suicide precautions" (p85) put in place. I believe the terms used such as 'wrist-slashers' carry with it judgemental and negative connotations and although this relates to research 39 years ago, it may seem that some negative attitudes still persist today. Shaw and Shaw (see Spandler and Warner, 2007) argue that current health services commonly respond to people who seek help with self-injury in a punitive and insensitive manner. Other researchers (Arnold, 1995; Harrison, 1994 and Pembroke, 1994) discussed how clients who self-harm were perceived negatively by inpatient services. Arnold (1995) found that women who self-harmed received services which were unhelpful, condemnatory, dismissive and punitive, communicating the message that this behaviour is unacceptable. Spandler and Warner (2007) argue that there is a desperate need for change from unhelpful attitudes focusing on control which are dismissive, patronizing and punitive, to ones which are more respectful, accepting, supportive and permissive. So it would seem that although such derogatory terms are no longer referred to in the literature suggesting some change, attitudes which are negative and judgemental perceiving a

client who self-injures as ‘sick’ and needing treatment still seem to be prevalent today.

Some theorists link intentional self-harm to an increase in the risk of suicide (Alper & Peterson, 2001;Cuellor & Curry, 2007; Cooper, Kapnur, Webb, Lawler, Guthrie and Machway Jones, 2005), with such understanding adding weight to advocating interventions based more on control in attempting to reduce this risk rather than focusing on respecting the client’s autonomy. However, other theorists disagree that suicide is directly linked to self-harm. Muehlenkamp (2006) refers to this behaviour as non-suicidal self-injury making the distinction between suicide and self-harm, and eight years before, Suyemoto (1998) established what she identified as an ‘anti-suicide model’ of self-harm, arguing that this behaviour actually has the positive function of staving off suicide in the client by managing overwhelming feelings.

Client Progression

Clients access therapy in order to help them overcome their problems or at least manage their problems more effectively and client progression can be assessed with regards to this aim. In terms of intentional self-harm, Scott, Nelson and Gruenbaum (1971) associated improvement and doing well in clients who intentionally self-injure if they engage with “constructive alternatives to mutilation” (p263). Therefore, these researchers appear to view client progression as inextricably linked to cessation of self-injury. As referred to earlier, there is a significant volume of research in line with the medical model within psychology, psychiatry, education, the National Health

Service and the Prison Service which appears to suggest the goal is to stop the self-injury. Such research describes how self-harm is linked to mental health disorders, so it would follow that there is an understanding of there being an ethical obligation to stop it (Shaw and Shaw, 2007). Medical professionals appear to communicate that this behaviour is not healthy and needs to be stopped, with patients in psychiatric and prison environments sometimes being placed in seclusion with their personal possessions which can be used to self-harm removed for their own protection (Liebling, Chipchase and Velangi,1997). In fact, many studies on self-harm have been carried out within a medical environment and Craigen and Foster (2009) argue that as such, findings tend to be biased. These researchers argue that clients in such environments have been subject to practices including observation, seclusion and restraint which have fostered fear, rejection in the client and misunderstanding of the issue of self-harm by treatment providers.

Craigen and Foster (2009) appear to suggest that what is needed in striving to understand this problem is an effort to view the issue from the client's perspective. As such, these researchers conducted a study where they interviewed clients who intentionally self-harmed enquiring into their perceptions of the treatment they received. Clients reported that the most helpful counsellors were those who listened with respect, understood and acted as a friend. They also rated the most unhelpful counsellors as those who did not demonstrate understanding and who forced ideas upon them. Like Craigen and Foster, Hansen (2002) also argues it is necessary to take on board the voices of people who self-harm, viewing the concept of client autonomy as essential to any understanding of the phenomenon, is in stark contrast to the medical model approach based on control. James and Warner (2005) views

are in line with this argument and suggest that professionals need to understand how clients engaging with this behaviour manage their “experiences, cognitions and emotions”.

In terms of a contemporary perception of progression, this seems to be split into two broad stances: those professionals/therapists who view progression as having the goal of stopping the self-harm, such as Laye-Gindu and Schonert-Reichi (2005) who see it as a ‘maladaptive coping strategy’, and those counsellors who perceive self-injury as a legitimate coping mechanism “which can have a range of positive functions” (Spandler and Warner, 2007, p vi) for those who do it and argue that having the emphasis on stopping the self-injury does not work (Harris, 2000; Hogg, 2001). Thus, the latter view is that progression can be perceived as managing the self-injury, such as taking better care of the wounds inflicted and progression being viewed as “doing less damage” (Spandler and Warner, 2007). These authors argue that having the emphasis on stopping self-harm leads to more severe self-injury in clients. In fact, Hawton, Townsend and Arensman (1999) take the pessimistic view that there is a lack of evidence for effective treatment. Craigen and Foster’s (2009) study appear to support this argument as half the participants, who were self-harming clients, found behavioural alternatives to self-harm unhelpful, did not like the counsellor putting too much emphasis on the self-injurious behaviour and most clients stated how they often manipulated their counsellor into thinking that they were improving and the cutting had subsided when it had not. These findings raise questions regarding the trustworthiness of claims made concerning client progression reported by therapists in terms of the client moving towards stopping self-harm behaviour. Research conducted by Duperouzel and Fish (2007) based in

a secure learning disability unit investigated staffs views when working with self-harming clients. Staff reported that they struggled to understand why the clients self-harmed and in many cases could not stop them from engaging in this behaviour. This resulted in staff feeling anxious and some stating that they would have preferred the "clients to be allowed to self-injure, but don't want to be blamed for a client's injuries" (p59).

Pengnally (2008) however, resists such 'therapeutic pessimism' and discusses how some professionals advocate user websites for clients who self-harm and offer a more optimistic attitude, advising the client to stay within safe limits if they need to self-harm Harrison and Sharman (2005) suggest that harm-minimisation helps the client to take steps to reduce the risk leading to a reduction in self-injury. Such replacement strategies like "cutting candles instead of their own skin" and caring for wounds is in line with the National Institute for Health and Clinical Excellence (NICE, 2004) which gives advice regarding self-management of superficial injuries. These guidelines advocate that harm minimisation techniques and alternative coping strategies should be considered for people who repeatedly self-harm. It also reports how service providers should consider information about dealing with scar tissue to a client who has scarring from previous self-injury. The suggestion here is that a client who successfully manages steps in harm minimisation is progressing.

There could be a number of factors which contribute to researchers and counsellors' views on progression. For example, if the main goal is to stop the self-harm, then client progression is likely to be viewed positively if this is achieved or if there is

movement in the process towards this aim. This is echoed by Huband and Tantam (2004) whose research study explores the value of different interventions with clients who engage in self-injury. Although the study does not explicitly state the goal is stopping the self-harm, strategies such as “being encouraged to talk about and express feelings from your past” (p423) are ranked according to how helpful they are in limiting the self-harm behaviour by the participant resisting the temptation to cut. Interestingly, the strategy which was viewed as the most helpful by clinicians was “regular discussions taking place between all staff involved in your care” (p 423), yet participants saw this as less helpful. It may be possible that patients perceived this strategy as a loss in their personal autonomy, with staff taking the lead in directing their care. Similarly, Sutton (2005) explores the concept of healing where the message is that healing is associated with gaining control and stopping the self-harm.

In comparison, Pembroke (In Spandler and Warner, 2007) like Harrison and Sharman (2005) explores harm minimisation and claims that “total cessation is not the only measure of progress” (p166), arguing that if a person does less damage and takes better care of themselves following the self-injury then this is progress also. This author discusses how her standpoint has been criticised and has heard challenges such as “a happy self-harmer is not progress” (p166). Her response to this criticism is that if clients can be helped to develop a range of coping strategies without excluding self-harm then this, along with good enough social and psychological support, can actually result in cessation. The argument here is that the counsellor, having the goal of stopping the self-harm, is less helpful than taking a more Client-Centred approach (Rogers, 1957) where the emphasis is on

acceptance, respect and encouraging autonomy in the client and if the client chooses to engage in self-injury as a way to cope, then it is more helpful to empathise with that choice. Fish (2000) discusses this balance between client autonomy and risk and suggested that although professionals appreciated the importance of client autonomy and a supportive relationship, sometimes they felt manipulated by clients, which would be likely to create a barrier in terms of empathy and impact on them striving to respect the client's autonomy in terms of treatment.

Therapists' views on client progression also appear to vary according to their therapeutic approach and what goals they have in terms of working with clients who self-injure. This may be to endeavour to direct the client to stop the self-harm, to minimise damage done or to work on other underlying aspects. Such variation appears to complicate any understanding when attempting to establish the most effective approach when working with intentional self-injury. Slee, Arensman, Garnefski and Spinhoven (2007) argue that Cognitive-Behavioural Therapy (CBT) is effective. They identify a framework with four specific mechanisms which they argue can bring change in the client, including building a trusting relationship, developing emotion regulation skills, cognitive restructuring and behavioural skills training. The argument is that a therapist working in this way can help a client focus on what to change when they have failed to progress. These researchers also argue that such a framework can be integrated into other theoretical approaches. However, CBT is renowned for focusing on the problem the client is experiencing so it may be difficult to integrate this into a more client-led approach or one which tends to focus on underlying causes, such as trauma focussed therapy (Schnurr, Friedman and Foy, 2003). Similarly, Sheppard and McCallister (2003) suggest "working beyond the

limitations of the medical model" (p442) can be more effective when working with self-harming clients. These researchers argue that intentional self-harm can be explained as a compulsion to re-enact past trauma. In this article, Sheppard refers to a case study taken from her own practice and suggests that society does not condone self-injury but has an expectation for people to recover and get on with their lives, resulting in the trauma and associated feelings experienced being invalidated. Therefore, Sheppard advocates an approach which resolves to validate the client's traumatic experiences by demonstrating concern and showing understanding.

Other research by Shaw (2002) indicates that many clients claim dissatisfaction in terms of treatment, affecting progression adversely and giving weight to the argument that it is important to include the views of clients who self-harm when attempting to gain any understanding of self-injury. The feminist approach tends to focus on women who self-harm having a history of physical and sexual abuse (Brown & Bryan, 2007) and takes a more client-led stance in favour of client autonomy. Here once the client is able to open up and talk about past abuse experience then this is likely to be viewed as progression. Another approach considers affect regulation as a significant feature of recovery and progression in the client. Andover, Pepper, Ryabchenko, Ornco and Gibb (2005) found that clients who self-injured scored highly on negative temperament, emotional dysregulation, depression and anxiety measures, so progression here would be viewed as the client beginning to talk about, own and express their emotions. With regards to the client gaining an insight into why they self-harm, Gardner (2001) who is of the Psychodynamic school of thought suggests that insight borne out of an unconscious

psychic conflict emerging into conscious awareness is significant in terms of the client's process.

Therefore, there does seem to be various opinions relating to client progression, although I could not locate any research specifically identifying the variation of counsellors' perceptions.

The impact on the counsellor

When considering the impact such work has on the counsellor, Favazza (1989) stated "of all disturbing patient behaviours, self-mutilation is the most difficult for clinicians to understand and treat." (p143). He described how therapists can experience helplessness, horror, guilt, fury, betrayal, disgust and sadness when working with clients who intentionally self-harm. Thus, such work is likely to be extremely challenging especially if the self-injury is extreme, leaving the client with permanent scars. Spiers (2001) discusses how a therapist may experience helplessness when working with traumatised clients. Sanderson (2006) suggests that such emotionally demanding work can lead the therapist to experience a range of negative emotions but also a "sense of powerlessness and inadequacy" (p287).

In fact a range of psychological conditions are described by theorists, which may be experienced by the counsellor when working with extremely stressed or traumatised clients. Figley (1995a in Sanderson, 2006) describes burnout as a "state of physical, emotional and mental exhaustion caused by long- term involvement in an emotionally demanding situation" (p397). He also defined secondary traumatic

stress as “resulting from helping or wanting to help a traumatized or suffering person” (p7). Sexton (1999) suggests that more recently this has been called ‘compassion fatigue’. Another contemporary concept, that of vicarious traumatisation is linked to the “cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client’s traumatic material” (Pearlman & Saakvitre, 1995a, p31). This was originally identified by McCann & Pearlman (1990) with a range of symptoms being noted such as anxiety, depression, post-traumatic stress disorder, concerns over personal safety, feeling helpless in terms of a client’s self-destructive behaviour and some counsellors experiencing cynicism, despair and loss of hope (Sexton, 1999).

Sheppard (2003) refers to a case study from her professional practice and discusses how she responded to a nineteen year old girl who had just self-harmed by cutting. Sheppard describes her response and chose `engagement and containment’ as the foundation for her interventions and although she understood this behaviour to be a sign in the client as a need to express her overwhelming feelings, Sheppard still experienced anxiety. The author argues for a gentle, empathic approach when responding to self-injury, taking the role of surrogate mother (Peplau, 1992) and being genuine in her non-judgemental respect for the client. Similarly, Nafisi and Stanley (2007) argue for maintaining a positive therapeutic relationship with the client throughout treatment and view this as a necessary goal as many therapists experience strong reactions to their client’s self-harm including disgust and blame. In contrast, Feldman (1988) cautioned against the therapist taking on too much responsibility for the client and argues that such over-concern was an attempt to rescue, likely to culminate in regression.

With regards to other impact on the counsellor relating to the complexity of the phenomenon of self-harm, I could not locate any research on how this could be a contributor to counsellor anxiety.

Conclusion

In the past, most research on intentional self-harm has occurred in medical environments with any attempt to understand the problem being linked to underlying pathology, diagnosis and interventions based around control in order to stop the behaviour. Although there was some appreciation that self-injury was an attempt at self-healing in the client, the general view was that it was a maladaptive way of coping. Although this view has persisted through time and up to the present day by some professionals, others perceive the behaviour as a legitimate coping mechanism in terms of managing overwhelming feelings and suicide ideation, with such contrasting stances having implications in establishing the most appropriate therapeutic intervention.

The issue of intentional self-harm is challenging for therapists working with such clients and authors identify various difficulties impacting on the therapist such as expectations to help the client stop this behaviour which can seem extremely problematic, different views on the best way to work with clients and whether the concept of client autonomy should be prioritised over client risk.

Methodology.

Philosophical perspective and design.

For this piece of research I chose a qualitative phenomenological study as it was my aim to establish a deeper understanding and hopefully obtain rich data from the participants whilst attempting to 'bracket off' (McLeod, 1994) my own assumptions. Initially I had an open mind with regards to the method for this study which began to emerge out of the nature and focus of my research question. I decided on an emergent design with the assumption that categories and meaning emerge out of the data (Willig, 2008).

I believed a necessary requirement in order to understand the informants' experience involved me attempting to put aside my own perceptions and experience to minimize any bias or direction from me. Maykut and Morehouse (1994) describe this aspect well, communicating how necessary it is for the researcher to be 'tuned-in' to their participants' experiences but also their own so as they can be more effective when aiming to bracket off their perceptions. They state:

> "*The qualitative researcher's perspective is perhaps a paradoxical one: to be acutely tuned into the experiences and meanings system of others – to indwell- and at the same time to be aware of how one's own biases and preconceptions may be influencing what one is trying to understand*". (Maykut and Morehouse, 1994, p123).

This is supported by Denzin and Lincoln (2000) who argue for flexibility and creativity in the early stages. I believe this approach to be more appropriate when enquiring

about counsellors' perceptions which is supported by McLeod (2003) who argues that the scientific tradition focusing on prediction and control of events is inappropriate when studying human beings. This qualitative enquiry which involves a more interpretative approach has been described by Taylor (1979) as a hermeneutic way of conducting research. The underlying philosophy proposed by Wilhelm Dilthey advocates that people can only be studied by way of a 'human science' (Spinelli, 2005). Some theorists such as Reason and Rowan (1981) have described qualitative research as a new paradigm, which is in contrast to previous scientific quantitative inquiry. In fact a dominant figure associated with establishing the philosophy of science is Sir Karl Popper (1959) who believed that theory needs to stand up to rigorous testing, so measurement and statistical techniques are viewed as essential features of the quantitative approach. However, for this particular study, my aim was not to establish a universal truth on counsellors' experience when working with self-harming clients. In contrast my aim was to learn more about the counsellors' perceptions of client progression and the impact such work has on the therapist with the focus being on inner experience; therefore a qualitative study was more applicable. In particular, the descriptive accounts of therapists was "an end in itself" (McLeod, 2003, p95) aiming to achieve an authentic perspective of the way the phenomena is experienced by the participants.

I was aware that my counselling experience of working with clients who intentionally self-injured has had a significant effect on my perceptions of client progression and had a personal impact on me at certain times such as when the client continued to self-injure despite continuing with counselling. However, my aim was to be open to new meaning and I endeavoured to lay aside my experience and focus on the

perceptions of the counsellors in this study, which I accepted may or may not be different to my own. Therefore, I aimed to investigate the phenomena from a fresh viewpoint, being open to new meaning. For this research, my interest in the perception of other counsellors, was to complete effective phenomenological reduction aimed at seeking new ways of seeing or understanding the topic.

Sampling.

I chose non-probability sampling which was not a random selection (Denscombe, 2007) due to there being certain criteria which needed to be met before people could be included in the study. In particular I chose a 'purposive sample' and as Denscombe (2007) suggests the sample includes participants who meet specific criteria which are relevant to the topic of the research.

My criteria and rationale for choosing participants included:

Criterion	Rationale
• **Over 5 years experience as a qualified counsellor**	The issue of self-injury can be challenging and I thought it was necessary for counsellors to have a store of experience in comparison to newly qualified therapists who may be more likely to find the experience over-whelming.
• **Experience of counselling clients who Intentionally self-injured by cutting and/or burning**	The focus of my study was on self-injury by cutting/ burning, so participants needed to have experience of this type of counselling.
• **Ongoing counselling supervision**	This was focused on the self-care of the participants, as the issue of self-harm can bring to the surface powerful feelings and it was my aim to give a space for exploration of these. Therefore, I wanted to ensure a good support network would be in place for each participant.
• **Access to a personal counsellor if needed**	(as above)
• **Varying** o **Theoretical orientation of the counsellor** o **Gender** o **Type of counselling field** o **Time since counselling a client who Intentionally self-harmed.**	To include some diversity in the sample. “ “ “

In order to search for participants, I prepared a poster (Appendix 3, p100) and sent this to a variety of organisations with a request for them to place my advertisement on their notice board. I also produced a leaflet size advertisement (Appendix 4, p101) which I made available at two workshops I attended where the organisers gave consent for them to be available. Searching for participants in this way increased the likelihood of me having no previous knowledge of them and minimised the risk of setting up any problematic dual relationships. Potential participants responded to my advertisement and following an enquiry I responded in writing by sending a letter (Appendix 5, p102) along with an information sheet (Appendix 6, p103) and a pre-interview questionnaire (Appendix 7, p105). On receiving these I assessed the applicants as to whether I would include them in the study and responded by letter. The acceptance letter for inclusion (Appendix 8, p107) was sent to the potential participant, and for those who were not to be included a refusal letter was sent (Appendix 9, p108).

With reference to the sample size, due to the fact I intended to obtain rich data, I conducted 5 in-depth interviews. A consistent feature in the sample was the age range of counsellors as all participants were between 40-50 years old. This was not an aim prior to gaining participants but occurred naturally during the process and a summary of the characteristics of participants can be referred to in Table 1, p25.

Table 7 : Characteristics of Participants

Participant	Work setting	Face-to-face	Online	Gender	Age group	Therapeutic approach	Years qualified	Time since counselled client who self-harmed
1	Abuse counselling	√		F	40-50	Integrative (relational, transactional analysis, person-centred, object relations)	5 +	Currently
2	Mental health counselling	√		F	40-50	Integrative (person-centred base, bodywork, psychodynamic, energy work)	5+	Currently
3	Hospital employee counselling	√		M	40-50	Integrative (person-centred, cognitive behavioural)	5+	2 years ago
4	Abuse counselling	√		F	40-50	Person-centred	5+	Within 8 months
5	School based counselling & Online counselling	√	√	F	40-50	Psycho-dynamic/ Systemic	5+	Currently

Data Collection.

The data collection for this study needed to be in line with the aim and nature of this investigation (Maykut and Morehouse, 1994). Being a qualitative phenomenological study, I chose face-to-face interviews which I believed would generate the type of sensitive and rich data which would give real insight into the detailed and personal experience of the participants. More specifically I chose a semi-structured interview framework with three broad questions which would allow enough flexibility for the topic to be explored. I purposely did not choose a structured interview as I wanted to keep the "spontaneous, free-flowing meanings" (McLeod, 1994, p80) articulated by the participants, whilst at the same time giving some sort of focus.

Prior to the study, an option I did consider was a focus group where the interviewer acts as a facilitator to explore beliefs and attitudes of the group members (Krueger, 1988). However, there are disadvantages in this approach also, such as the issue of time sharing linked to managing more dominant group members. I also wondered whether my third question, on the impact on the counsellor as a person, may have been too threatening to share in a group where the person does not have the same anonymity. With this in mind, I believed there would be a restriction to the potential of obtaining rich data. The advantage of choosing a semi-structured interview was that it gave more of a focus than an unstructured interview, yet giving more flexibility and deeper exploration than a structured interview. Although the structured interview tends to give more standardized data, I deemed it more important in this particular study to choose a semi-structured format where new information was more

likely to emerge. An issue for consideration here was that the more structured the interview, the more the power lies with the researcher. However a semi-structured interview is still not free from this unequal power dynamic and for this study I needed to be aware that the power-dynamics may be tipped towards myself as the researcher. Therefore, I strived to adopt a tentative Person-Centred approach where I intended to follow the participants lead as much as possible but without losing the focus.

For this particular research, I felt it would be helpful to carry out a pilot study, which I recorded to make reflexivity on this more effective. I found this gave valuable feedback on whether my questions were phrased effectively to help the participants talk about the topic and how long the interview was liable to take. The participant for the pilot study was a colleague, so I needed to be aware of any bias and how this may impact on any data collected in the pilot study. Following the pilot study I asked the volunteer whether she felt that other people may have any difficulty answering the questions. In fact she stated that she had found the interview questions helpful for her to explore the topic. McLeod (2003) suggests that another advantage of completing a pilot study is that due to the practice situation it may contribute to the researcher feeling more confident in the actual research interview situation and I can confirm this point. Following the pilot study I felt much more prepared for the actual interviews.

When constructing the questions, my rationale for question 1 `Could you talk about your work with clients who intentionally self-injure?' was that I needed a lead-in to

this particular sensitive issue and felt a question which was broad in its scope could help the participant to begin talking freely. With reference to my second question `What are your perceptions about moving forward in terms of self-injury?', when attempting to construct this question I initially found this difficult. My aim was to investigate counsellors' perceptions of client progression but I needed to ask a question which did not appear to put the participant on the spot. I also needed to ask a question which was free from bias as much as possible and although I was not completely content with the question as it stands, this seemed to be the closest in terms of acquiring views on progression, which in itself suggests a forward movement. My third question `Can you talk about how such work has impacted on you as a person?' was directly linked to the personal impact such work has had on them and again I felt this needed to be as broad as possible.

Reflecting on this process prior to the interviews helped me to focus on possible potential blocks in the communication between myself as researcher and the participants. In particular, with the first opening question I anticipated that a possible reply by participants may have been 'Where do I start?' I identified a possible further response by me to help the participant to begin talking of, 'what are some of the recurring themes that come up more often?' In a similar way I constructed sub-questions for questions 2 and 3. A summary of interview questions and sub-questions can be referred to in Table 2 (Appendix 10, p109).

In order to help put the participant at ease I constructed an interview guide (Appendix 11, p110) which they read before commencing the interview and I kept

this simple so it was easy to read. I also constructed an aid-memoir of interview questions (Appendix 12, p111) to help me facilitate the interview process smoothly.

At this early point in my research project I believed it was absolutely necessary to have a tentative Person-Centred Approach (Rogers, 1957) whilst asking these questions and I intended to use my reflective skills of acquired from counsellor training to facilitate the participants to talk. Willig (2008) states "..it is a good idea to restate interviewees' comments and to incorporate them into further questions throughout the interview" (p25). However, at the same time it was essential to keep in the researcher's role which I was conscious of throughout the process. Kvale (1983) makes the point that a qualitative research interview can be a positive experience for both participant and researcher due to the topic being of interest to both. If the interview is handled well by the researcher, the interviewee may find the process enriching.

Data Analysis.

With this particular piece of research, I was aware that I do have certain experience and assumptions concerning the subject matter and although I endeavoured to put these aside, it has been argued that it is impossible to put aside all assumptions (Elliott, Fischer and Rennie, 1999). McLeod (1994) suggests it may be helpful for researchers to "find new ways of seeing or understanding the object of inquiry" (p91). Geertz (1973) suggests that a successful phenomenological exploration will give qualitative data described as 'thick data' of the individual's experience. Unlike the

traditional scientific deductive method where hypotheses are generated before beginning the study and the data collected is identified and known as variables (Maykut and Morehouse, 1994), the Constant Comparative Method used in this study, is inductive in nature. What ‘”becomes important to analyse emerges from the data itself, out of a process of inductive reasoning” (Maykut and Morehouse, 1994, p127).

To enable me to identify each step in this method and crystallise a “clear path for engaging in the analysis” (Maykut and Morehouse, 1994, p127), I merged the steps involved in preparing the data for analysis with the Constant Comparative Model (Glaser and Strauss, 1967) adapted from Maykut and Morehouse (1994) to produce a table summary (Appendix 13, p112). To prepare for the data analysis I transcribed each interview and began analysing each one in depth. The first step involved me unitizing the data and identifying smaller units of meaning on the transcripts giving each unit of meaning a code based on who the participant was and the specific page number on the transcript. Willig (2008) makes the point that this method breaks down the categories to “smaller units of meaning enabling the full complexity and the diversity of the data” (p36) to be recognised and linked together. For the actual data analysis I used Constant Comparative Analysis (Glaser and Strauss, 1967) with the data being sorted through systematically with the coding process moving back and forth between identifying similarities and differences between emerging categories. At this point in the process I created rules of inclusion (Maykut and Morehouse, 1994) (Appendix 14, p113) so I could decide whether to include or exclude a particular unit of meaning. Further into the analysis relationships and patterns across categories were established eventually leading to a series of propositions

(page 62) which summarised the significant themes and patterns gleaned from the data (Lincoln and Guba, 1988).

Establishing the findings for this study involved various stages and I constructed table 12 (Appendix 15, p115) in an earlier stage of the analysis process to show how some units of meaning fit into more than one category. After further refinement I constructed a table summary of findings identifying categories, subcategories and relating these to the participants in the study (Table 3, page 41).

Ethical considerations.

Bond (2004) suggests that researchers who work ethically need to achieve adequate trustworthiness and integrity in terms of the research relationship, the discovery of new information, the way this is communicated and when applying the research to practice. Thus, ethical issues need to be considered thoroughly and the first step with reference to this study was to obtain ethical approval by the ethics board (Chester Univeritsy, 2009) by submitting a research proposal. Willig (2008) advocates researchers having a responsibility to protect their participants from harm or loss when taking part in a study. She extends this further by stating that the participants' "well-being and dignity" (p19) should be one of the aims of the researcher carrying out the study. For this study I strived to ensure I met these ethical requirements. The subject matter of intentional self-harm is a socially sensitive issue which can bring strong emotional reactions and seeing that one of my questions relates to the impact on the counsellor, I believed there was a requirement

to be as sensitive as possible during the interview. I also considered the self-care of the participants, an essential aspect as they would be invited to explore their phenomenological experience. This may have risked the interviewees feeling vulnerable during their exploration and this was one of the reasons why I decided to search for experienced counsellors who already had at least five years post-qualified experience based on the rationale that they were likely to have engaged in continued personal development, ongoing supervision and have access to a personal counsellor if needed.

In order to remain ethically aware during this study, my starting point was to adhere to the five ethical considerations outlined by Elmes, Kantowitz and Rosediger (1995) which are informed consent, no deception, right to withdraw, debriefing and confidentiality. With reference to informed consent, as stated I supplied potential participants with an information sheet outlining the aims and procedures of the study so that they could give informed consent to take part which was given in written form (Appendix 16, p119). I also intended to avoid any deception altogether and have a transparent approach with participants to minimise any risk relating to this issue. In particular, I gave participants the space to ask any questions at any time during the research process which may have occurred before, during or after the interviews. I believed another important aspect of informed consent involved giving the interviewees the opportunity to have a copy of their transcript to read and check if they so wished. I also communicated to participants that they had a right to withdraw at any time, with no fear of being penalised in any way. I was aware that it was feasible that once an interview was completed, the transcript typed and given to a participant, they may want to withdraw. Although, this would be time consuming

where I would need to find a replacement, I believe this was far outweighed by my intention to protect the participant from harm. This view is supported by The World Medical Declaration of Helsinki (2000) requiring that the wellbeing of the human subject needs to take precedence over scientific inquiry.

In terms of debriefing after the data collection, I again informed participants of the full aims of the research and confirmed their agreement to use the material in any possible future publications arising from the study. Participants were also given the opportunity to give feedback following the interview and to ask any questions. In fact, all participants saw the interviews as a positive experience where they appreciated the opportunity to share their views.

As a practising counsellor the issue of confidentiality is central and within research it is considered just as vital, as "...confidentiality regarding any information about participants acquired during the research process" (Willig, 2008, p19) needs to be maintained and with this in mind I identified participants by a number. Another aspect of confidentiality concerns the storage of information concerning the transcripts and tapes and I kept these stored safely when I was not working with them, with no identifiable personal details attached to these resources. Participants were also informed which university staff would have access to the raw data such as the research supervisor, tutors on the course and the external examiner, with the university's policy for the researcher to hold this raw data for five years before being shredded. Bond (2004) specifically recommends that researchers inform participants that they will have ongoing supervision just as it is a requirement in

counselling and considers this to be best practice and in my information sheet, I included this fact.

I referred earlier to these requirements being a starting point for me as a researcher concerning ethics and would echo the Brinkmann and Kvale (2008) argument that all potential ethical dilemmas cannot be accounted for in the planning stage. I was aware that it may have been likely that ethical problems would emerge throughout the research process so I aimed to remain ethically attuned during the whole study. Willig (2008) suggests that the risk of ethical dilemmas surfacing as the process moves along is likely to be more apparent in qualitative research, as the participants have more freedom to explore due to the more general type of questions being asked.

As referred to earlier I advertised to avoid including participants whom I already knew, minimising the risk of forming dual relationships. A dual relationship such as interviewing a colleague, may "tip the direction of fulfilling the needs" (McLeod, 2003, p174) of the researcher. This would likely have an impact on 'informed consent' as it may be more difficult for a potential participant to refuse a colleague or friend. McLeod discusses another consequence of a dual relationship where a colleague or friend may perceive themselves as a special participant compared to the other participants and this may show itself in them striving to give the research the 'right' material, so tailoring their responses. The only exception to this with regards to the present study was during the pilot interview where I asked a colleague to volunteer. The aim was to identify any problems with my questions or interview technique which

I could then adjust to make sure that the actual research interviews ran as smoothly as possible. A final feature I considered to be important concerning ethics was "responsibility to self" (Bond, 2004). Therefore, I felt it necessary for me to personally meet the criterions regarding ongoing supervision and access to a personal counsellor (page 23) for myself as researcher.

Validity and trustworthiness.

McLeod (1994) argues that the concepts of validity and reliability for a qualitative study should be judged on the basis of trustworthiness. In order to establish trustworthiness in this research study I have aimed to produce clear and detailed information about each step in the process (Appendix 13, p112). The goal was to conduct a qualitative phenomenological study as an emergent design based on semi-structured interviews and it was my intention to gain rich data which would represent an authentic account of the way the phenomena was experienced by the participants. All participants had over 5 years experience as a qualified counsellor, experience of counselling clients who self-harmed by cutting and/or burning, but varied in terms of gender, their counselling orientation, working in different counselling fields and in the time since they last counselled a client who self-harmed (page 23); this variation contributed to the trustworthiness of the study.

With regards to the data analysis, I aimed to produce an audit trail of each step in the analysis and took photographs to record various stages of the process (Appendix 17, p120-123). I also kept a journal throughout the procedure, recording some of my

thoughts, perceptions, feelings and ideas as the research progressed (Appendix 18, p124).

Throughout this project I have also had regular meetings with my supervisor to discuss and check out my ideas, perceptions and decisions. I found her views effective in providing another perspective at various times. With regards to member checks (Lincoln & Guba, 1985), I asked participants whether they would like a copy of their transcript interview for them to refer to and check if they so wished; only one participant wanted to take up this offer to confirm its accuracy. Lincoln & Guba (1985) do suggest that multiple methods of data collection also contribute to the overall trustworthiness of a research project. However for this study only one method of data collection was used, although participants did complete a pre-interview questionnaire as well as being tape-recorded during interview.

Stiles (1993) identified a set of criteria for establishing validity in qualitative research and for this particular study I referred to this criteria, such as aiming to be as thorough as possible in describing each step in the process from the initial proposal to the final dissertation which would hopefully give 'plausibility' of findings. Considering the issue of contextualisation, I explored the wider context by referring to research taken from the literature and constructed a literature review as part of this dissertation. This included a critical discussion of established research findings including the historical and social themes related to the phenomena of self-injury.

When reading around the topic, I endeavoured to have an open mind and to consider competing explanations to avoid supporting my 'pre-existing biases' and hunches which I hoped would minimise the risk of other readers discounting my findings. In order for me as a researcher to be assessed as credible, I aimed to have a transparent approach and I believed the journal contributed to meeting this goal. Mcleod (1994) supports this approach and regards reflexivity as an essential feature of any qualitative study. Another feature I deemed to be essential in terms of validity is triangulation (McLeod, 1994), which would indicate which meanings are valid. I sifted and sorted the core meanings and as previously stated, offered participants copies of the transcripts if they wanted to read and check them.

With regards to replication, this study aimed to achieve rich phenomenological data from a small number of participants so I expected that for this study subjectivity and variation in findings and interpretation would be more liable when aiming to replicate the study than for a quantitative study. However, I was as thorough as possible in my methodology which I believe went some way towards reliability for another researcher replicating a similar study.

Limitations

A limitation with regards to this research was the fact that only a small number of participants, five in all, were interviewed. Therefore it is not appropriate to make any generalisations from the findings in this study. Although I obtained rich data, this was gleaned from a small number of participants and it was their unique perceptions

I discovered rather than any universal truth which could be applied generally. In order to attempt to overcome this limitation, further research with a larger group of participants could be done and researchers working as a team could possibly minimise the time-consuming factor related to face-to-face interviews and analysis. (Maykut and Morehouse, 1994). This time-consuming issue is one of the main disadvantages of interviewing and extends to arranging the interview, conducting the actual interviews, transcribing the tapes from each session and the analysis (McLeod, 1994). Loftland (1971) suggests that when structuring a qualitative interview, it may help to make a list of potential questions, arrange them into various themes and to carry out a pilot interview which should help for a smoother process, and in this present study I took all this advice onboard and incorporated these aspects into the research process.

Another disadvantage is that there is a risk that the informant may be strongly influenced by the interviewer as a result of the unequal power-balance due to the researcher being the one to ask the questions. McLeod (2003) goes on to talk about the researcher possibly being viewed as the 'authorative expert'. However, my own counselling orientation of being Person-Centred/Integrative involves me attempting to equalise the power-balance as much as possible (Rogers, 1957) and attempting to facilitate self-reliance in the client. The underlying principle of the client as expert is central and although in the interviews I was the one asking the questions, I attempted to keep the power-balance as equal as possible throughout.

Willig (2008) discusses how the issue of power is commonly associated with the concept of ethics and Willig (2008) argues that in a qualitative study this can be more

covert and subtle. The rationale being that the relationship in this type of study is likely to be more personal which may increase the risk of abuse of trust especially if there is fakeness in this relationship to obtain information (Dunscombe and Jessop, 2002). With regards to this point, my own counselling approach included offering the core condition of congruence (Rogers, 1957) and I saw this as essential in order to be genuine and authentic in the research relationship.

Findings.

On completion of the analysis five categories were established and in each of those sub-categories were identified. Table 3 (page 41) shows how all five participants were applicable to each category and which correspond to the various sub-categories. A table was constructed of participants' comments relating to categories (Appendix 19, table 13, page 128).

Tale 9: Summary of findings

Category		Subcategory	Participants				
1.	Impact on the Counsellor	Counsellor experiencing intense emotion:	P1	P2	P3	P4	P5
		shock					
		sadness					
		anxiety					
		anger/frustration					
		affecting counsellor's self-confidence					
		idiosyncratic impact					
2.	Necessary requirements of the counsellor when working with self-harm	A need to:					
		be a robust enough container without being overwhelmed , avoid showing shock or reacting with panic					
		not focus on the act of self-harm					
		focus on the act of self-harm					
		invest in self-care for the counsellor					
		give advice on how to care for wounds					
		communicate consequences of scarring and check out the risk of severe self-harm and suicide					
3.	Counsellor having an agenda for change to stop the self-harm	Implicit agenda for change					
		Explicit agenda for change					
4.	Counsellor's perception of client progression	Decrease in the level of physical damage					
		Client now using replacement strategies					
		Affect regulation – client now talking about their feelings					
		Client gaining insight into why they self-harm					
		Progression is not simply about stopping					
5.	Counsellor's perception of why clients self-harm	Self-harm as a response to overwhelming feelings					
		Self-harm as a way of coping					

Impact on the counsellor

Category 1 identified as 'Impact on the counsellor' relates to the participants experiencing a range of emotions, including four participants experiencing shock, three experiencing sadness, all five experiencing anxiety and two experiencing anger or frustration. Participants described experiencing such intense emotions in various ways with Participant 1 describing her feeling shock,

> *...it's like an impact, like a thud or a thump or...*
> *I do find it shocking.* (Appendix 19, p128)

Whilst participant 2 described her feeling of shock related to her first counselling experience of working with a client who self-harmed by stating,

> *I didn't sleep for three days...immensley shocking,*
> *immensely shocking (Appendix 19, p128).*

Participant 3 stated,

> *Yeah...and it was oh my god, can I really do this,*
> *I remember the shock factor...but I was more*
> *shocked at myself thinking I don't know what to do*
> *with it* (Appendix 19, p128).

Participant 4 shared how the visual impact affected her,

Yes....I do get shocked sometimes and I do feel upset sometimes especially if somebody is self harming in a very visual way.....the times when I have been shocked... been out of the ordinary.... somebody turning up who has just self-harmed and there is blood all over them (Appendix 19, p128).

With regard to sadness, three participants experienced this emotion and Participant 1 stated,

I feel a lot of grief when it's being talked about. Can feel quite sad, a sadness about it (Appendix 18, p128).

Participant 5 shared her views on experiencing sadness,

You know it's very sad...it's very hard with young people...it's heartbreaking..the sadness does stay with me...I can't always leave it behind (Appendix 18, p128).

In terms of anxiety, all five participants said they experienced this emotion and Participant 1 refers to a powerful metaphor,

Initially there was a bit of all at sea...yeah below the water...yeah...I'd feel overwhelmed (Appendix 19,

p128).

Participant 4 described how she is most anxious when the self-harm becomes more severe,

> *My main worry is that it gets worse....and the risk of death or you know..serious physical problems.. ...increasing the longer people do it...for it to slip into suicide territory* (Appendix 19, p129).

Similarly Participant 5 described her anxiety relating to her client engaging in severe self-harm or suicide,

> *It was very hard at first.....I was always wanting not to do it....it's heartbreaking.....it felt very insecure and not very safe..I felt a bit helpless at times. It comes out of absolute terror....having to live with that I couldn't live with the responsibility of I didn't do every-thing I could do..but who's to say that I couldn't make a mistake and that is around* (Appendix 19,p129).

Anger and frustration was experienced by two participants when working with clients who intentionally self-harm and Participant 2 stated,

> *I was actually livid..pisses me off...people going up to A&E and don't get any anaesthetic...they are treated terribly* (Appendix 19, p129)
>
> and,

he put her (the psychiatrist) on *ECT twice a week for 15 months...I was actually livid* (Appendix 19, p129)

Whilst Participant 4 shared her frustration,

I think it would affect my patience (when the client does not stop self-harming) (Appendix 19, p129).

In terms of how working with the challenging issue of self-harm and it impacting on the counsellor's self-confidence, three participants (P1,P2, P3) communicated that it had undermined their self-confidence especially during the early days of their practice with Participant 1 stating the intensity of that impact,

When I first began practicing, I was really alarmed by self-harm (Appendix 19, p129).

Participant 3 talked about him not feeling capable to work with this issue,

*It did I think (*affecting counsellor's self-confidence*) when I first saw a client with self-harm and I referred her* (Appendix 19, p129).

However, two participants (P4, P5) stated that such work had not affected their self-confidence with participant 4 describing her resistance to this impact,

I have worked long and hard to get to a place where I don't lose my self-confidence...and I'm not willing to give that up (Appendix 19, p129).

When asked whether such work had affected her self-confidence, Participant 5 stated,

Don't think so....no.....I don't see it that way...I just see it as the kids are in pain and I'm there for them (Appendix 19, p129).

Another impact included two participants (P2,P3) describing idiosyncratic impacts of self-harm and Participant 2 shared how such work had had a personal impact and gave her motivation to continue such work,

I think for me my god....I think I've had a very bloody happy life...thank you very much...with regards to this... is horrendous for people and I want to do something.... it's not a fight it's almost a driver (Appendix 19, p129).

Participant 3 stated a positive impact,

It was tapping into something in me...some childhood pain...in a positive way I think it helped me with...acceptance of people generally (Appendix 19, p129).

Necessary requirements of the counsellor

Category 2 was identified as 'Necessary requirements of the counsellor when working with self-harm' and is comprised of six sub-categories. Four participants shared how there is a need to be a robust enough container in the counselling relationship and to avoid showing shock, not to get overwhelmed or react with panic to self-harm or threat of suicide and Participant 1 stated,

> *..and to be a robust enough container that I don't get overwhelmed...I can be with them...and help them...people are very alarmed by it..,,it is linked too closely with suicide I think...can stir up a lot of panic...can jump to stop it* (Appendix 19, p129-130).

In addition Participant 3 said how it is important to,

> *Not show any sort of shock....because I didn't kind of react in any way....I just let her tell her story...not to be dramatic.....not to be terrified* (Appendix 19, p130).

Participant 4 supported this view,

> *...and actually not being overwhelmed by it*
> (Appendix 19, p130).

Another requirement shared by four of the participants (P1,P2,P3,P4) was not to focus on the act of self-harm in the counselling session with the client.

> *I don't tend to focus on the activity actually* (Participant 1, Appendix 19, p130).

Participant 2 also shared that she does not focus on the act of self-harm but instead on what has contributed to them engaging with this behaviour,

,

> *When people are coming in self-harming, I don't look at that...but to focus on what has got them to that point* (Appendix 19, p130).

Participant 3 supported this approach,

> *..to show....kind of show interest in the person and not the cuts* (Appendix 19, p130).

Participant 4 was in agreement,

> *I think I try not to focus on the frequency and the act of self-harm in itself because if that starts to happen then the self-harm becomes the client rather than the client* (Appendix 19, p130).

However, not all participants were in line with this thinking and Participant 5 described how risk is a significant feature of such work,

> *There's always going to be a safety issue...it would feel like collusion..letting them talk about it without* (having the goal)*...to check out whether the client is ....suicidal or can get immediate car*e (Appendix 19, p130).

In addition, although participant 2 had said she does not tend to focus on the self-harm with the client she also communicated some ambiguity,

> *...if I am concerned they are harming themselves... it is not about me shying away from that in any way* (Appendix 19, p130).

In terms of there being a requirement to invest in the self-care of the counsellor, three participants (P1,P3,P4) referred to this, including there being a requirement of

attaining a good supervisor and learning some coping methods to minimise any personal impact. Participant 1 shared her thoughts on an essential requirement,

> *Getting a really good supervisor* (Appendix 19, P130).

Participants 3 and 4 supported this view,

> Participant 3:
> *The value of supervision is so important..... I've learnt coping methods to deal with it..it can be a visualisation* (Appendix 19, p130).

> Participant 4:
> *...need a good support system in place..... have a very good supervisor* (Appendix 19, p130).

Another requirement centred on the need to give advice to the client on how to care for wounds and four participants (P1,P2,P4,P5) stated how they communicated this.

> Participant 1,
> *I do check that...whether people are looking after themselves...have they got antiseptic* (Appendix 19, p130).

Participant 2,

Saying....it is far better to be safe and do it than it is to use dirty blades and get other infections (Appendix 19, p130).

Participant 4,

To be pragmatic about the after-care...taking care of yourself after you have self-harmed (Appendix 19, p130).

Participant 5,

Let's check how you are doing it, are you...how dangerous is it...can you make sure it's clean (Appendix 19, p130).

The final subcategory under this category was the need to communicate the consequences of scarring to the client and two participants (P3,P4) indicated this.

Participant 3,

Discussing....will never get to the point where somebody is never going to see them (scars) (Appendix 19, p130).

Participant 4,

> *Informing the client...scarring..if it is visible, is a constant reminder.....there is a social impact* (Appendix 19, p130).

Counsellor having an agenda for change

The third category of the 'Counsellor having an agenda for change to stop the self-harm' involved all five participants communicating this. Three participants (P1,P3,P4) all had an implicit agenda for change with Participant 1 stated,

> *Trusting that...given the right environment this organism will thrive and not have to do that anymore* (Appendix 19, p131).

Participant 3 discusses an emotional response, with a requirement to explore this in counselling supervision,

> *the congruent bit of me would be sad as I would wish for them to have a better way of coping...that had no risk to their health...I would go to supervision and say, what I am really feeling is I wanted you to stop...please stop* (Appendix 19, p131).

Participant 4 shared her views on this,

> *As a long term coping strategy it tends to peg people into a corner.....and I don't want to be trapped in a situation where....nothing ever changes...and I wouldn't want that for the client either* (Appendix 19, p131).

The other two participants (P2, P5) had an explicit agenda for change and Participant 2 stated,

> *..let's work towards you stopping the self-harming. ...it's okay and you deserve better....you are starting to respect yourself...if this isn't stopping I want to know why...what is it that is going on that you are not able to take responsibility for here and start to unpack this at a deeper level* (Appendix 19, p131).

Whilst Participant 5 describes how she talks about gives advice on what strategies the client can use to work towards stopping and considers an underlying mental health issue to be a barrier to progression.

> *Helping them to take the next step to get support to help them find different coping mechanisms*... *It can be difficult to change...with Borderline*

Personality Disorder (Appendix 19, p131).

Counsellors' perceptions of client progression

'Counsellors perceptions of progression' was identified as the fourth category and all five participants had various views on this. Three participants (P1,P2,P5) identified a decrease in the level of physical damage as being an indication of progression.

Participant 1,

I'll ask well is it changing in nature or frequency or is it raised...I'll ask....and it may be that there is some report that it is not as bad...like the cutting is not so deep (Appendix 19, p131).

Participant 2 ,

So I suppose it's a bit of a gage for me actually.... is it pulling back...in terms of where the process is going....self-harm is an easy signal because it is there (Appendix 19, p131).

Participant 5,

And they might come up and say you know what, it is actually 6 weeks, 14 days and 3 hours since I last did anything to myself (Appendix 19, p131).

Two participants (P4,P5) saw progression as linked to the client now using replacement strategies.

Participant 4,

> *People came up with very idiosyncratic ways of moving away from self-harm...it doesn't have to be cutting you... it could be cutting anything..a box of candles...she would rip those to shreads* (Appendix 19, p131).

Participant 5,

> *Yeah, stay with them and help them get the right help.... but quite often they say to you, what do...what have other people tried?....so well you can say...the usual...elastic bands, dry-ice, ice-cubes* (Appendix 19, p132).

A further view involved four participants (P1,P2,P4,P5) stating that affect regulation, with the client now able to identify and talk about their feelings indicated progression.

Participant 1,

> *I think it is about not having developed affect regulation then moving to talking about discreet emotions is a good indicator* (Appendix 19, p132).

The other 3 participants whose views were consistent with this stance,

Participant 2

> *Once she got into it and explored it...she'd just sob and sob and sob and sob..but my goodness it was just so cathartic for her* (Appendix 19, p132).

Participant 4,

> *Use it to moderate their feelings* (Appendix 19, p131).

Participant 5,

> *Now feeling the pain and moving away from*, *when they feel the pain....they don't feel the emotional pain* (Appendix 19, p132).

Clients gaining an insight into why they self-harm was another indicator of progression as communicated by two participants (P3,P5).

Participant 3,

> T*he first step I would see ..moving forward..is them gaining an insight into what it is all about rather than just doing it...when they start to see it in that way, choosing to stop it then....so that is one way forward* (Appendix 19, p132).

Participant 5,

> *They slowly change from being...seeing it as positive, to acknowledge it as maybe not quite as positive as they first thought. They begin to see it completely different to how they did do* (Appendix 19, p132).

The final sub-category under perceptions of progression was identified as 'Progression was not simply about stopping the self-harm'. All five participants indicated this,

Participant 1,

> *I wouldn't be whipping away somebody's comforting mechanism. I would hope that it would happen little by little* (Appendix 19, p132).

Participant 2,

> *If you've got a crutch there and there are different ways I can deal with this....I can kick the crutch from underneath you the you're going to fall down...and you have to pick yourself up or I actually work to the point where you throw your own crutch away* (Appendix 189 p132).

Participant 3,

> *I don't think the step forward is to just stop...for me.... the step forward is that self-understanding that says oh well now I can grasp why I'm doing it...what I am doing* (Appendix 19, p132).

Participant 4,

> *But there are ways of minimising at least the social impact of it....cutting in a place which is less risky in terms of physical damage.....such as away from tendons. I think a lot of the work about self-harm is about unpicking viscous circles from the past* (Appendix 19, p132).

Participant 5,

> *Encourage them to talk...but not to give up self-harm immediately...not being judgemental or saying....just don't do it because...that's not really going to help them* (Appendix 19, p132).

Counsellors' perceptions of why clients self-harm

The category identified as 'Counsellors' perceptions of why clients self-harm' included all five participants communicating their views on this. There were various views on why clients self-harm?

Participant 1,

> *It's usually about desperation...usually despair is a very strong word...overwhelmed...not okay feeling definitely not okay..feeling very bad.. kind of wanting some peace* (Appendix 1, p132).

Participant 2,

> *Probably generally abuse driven actually* (Appendix 19, p132).

Participant 3,

> *About...well...it's...around when people haven't got an identity or they have been given a very negative identity* (Appendix 19, p133).

Participant 4

> *Client's use it to moderate their feelings...sometimes they do it as a kind of punishment...in my experience it is part*

of a bigger picture and as a result of bigger problems (Appendix 19, p133).

Participant 5,

Its...a lot..sexual abuse is common...in their history. bullying is a big factor, family issues, border-line personality disorder...sometimes a deprived background...yeah so a lot of different factors really...the self-hatred, self-disgust and dislike....not being worthy...some of it is...look how bad things are...this is a bad way of doing it because I am a bad person... I'm hurting. But it is like their own hug so they don't see it as a negative they see their cutting as very positive...because it makes them feel better emotionally...like making the physical pain take away the emotional pain (Appendix 19, p133).

Self-harm perceived as a coping mechanism was also shared by all five participants,

Participant 1,

I believe it is a way of coping (Appendix 19, p133).

Participant 2,

If this is the way you are coping at this moment in time.. then be safe..that's absolutely fine (Appendix 19, p133).

Participant 3,

> *So a coping mechanism which has worked for years and years...sometimes for some people it is a coping method even if it isn't working anymore...almost still use it but to carry on and make it work* (Appendix 19, p133).

Participant 4,

> *If that is the only coping mechanism people have it gives them relief then that in itself is something...what started off as a coping mechanism can now be more like hooking them in and keeping them there...something they can't get out of any more* (Appendix 19, p133).

Participant 5,

> *It's working for you for now...it's okay, but let's check how you are doing it...how dangerous is it?* (Appendix 19, p133).

(For a complete record of each participants comments relating to categories and subcategories please refer to Appendix 19, p128).

From these findings the following 4 proposition statements were constructed, establishing the final outcomes of this study.

Table 10 – Outcome propositions.

Number	Proposition
1	The counsellor experiences intense emotion when counselling clients who self-harm including shock, sadness, anxiety, anger and frustration
2	Perceptions of progression vary, with counsellors having an agenda for change to stop the self-harm married with the seemingly contradictory attitude of respecting the client's autonomy when using self-harm as a legitimate coping mechanism
3	There appear to be many contradictions in terms of the process and counsellors struggle to manage the tensions between these multiple dualities
4	There are challenging, yet necessary, requirements of the counsellor when working in this field.

Discussion

This phenomenological study focusing on counsellors' perceptions of working with clients who intentionally self-harm has established five main categories. The first category 'Impact on the counsellor' was related to the counsellor experiencing intense emotion when counselling clients who self-harm including shock, sadness, anxiety and anger/frustration and all participants reported having experienced such strong emotions at times. In the literature review, I referred to Favazza (1989) who claimed that clinicians feel a combination of helplessness, horror, guilt, fury, betrayal, disgust and sadness. This present study supports Favazza's findings and are equated to the outcomes here of shock, anger and sadness. In fact, the feeling of helplessness reported by Favazza, was also supported by one participant in this study. Walsh (2006) identifies three main categories which therapists experience when working with intentional self-harm including anxiety and fear, frustration and anger, sadness and hoplessness,. In this present investigation four participants said they had experienced shock, with Participant 1 describing this experience in a physical way by saying,

> *'...it is like an impact...like a thud or a thump or...I do find it shocking'*.

Rothschild (2006) describes how "chronic stress exacts a great toll on the body and mind" (p95) especially if the state of shock persists without it being explored or tools put in place to dissipate it. I would echo Rothschild's view and argue that it is likely

to have a negative impact, with repercussions for both the counsellor and the counselling process. Rothschild also suggests that counsellors working with clients, who are extremely stressed, are at "high risk of compassion fatigue or vicarious trauma" (p104) when they remain unaware or ignore their anxiety which can build and manifest into exhaustion, negative emotion, distorted thinking, unhelpful behaviour and physical distress. This author discusses how the therapist's self-care and effective supervision are essential to minimise such negative effects.

In the present study, sadness was an emotion shared by three of the participants in response to such work. Alderman (1997) would support this and describes her experience of working with a client who self-harmed stating, "...seeing the fresh jagged wounds on arms had a major impact on me. I imagined the great amount of pain this girl must have...and I felt quite sad" (p192). Sutton (2006) identifies such 'empathic sadness and grief' as possibly having a powerfully negative impact on the process, with the counsellor having a tendency to avoid focusing on the self-harm and even dissociating from the client.

Whether such intense emotion experienced by the therapist is detrimental to the counselling process is questionable, but Walsh (2006) argues that sadness has no place when working with clients who self-harm. He argues that clients will interpret this emotion as the situation being hopeless. The suggestion here seems to be that the therapist would need to put such sadness to one side and certainly not express it in the session. This may prove to be difficult for a counsellor working in the Person-Centred (Rogers, 1957) tradition where congruency and realness is seen as an essential feature of the relationship. The argument here is that feeling a powerful emotion like sadness and attempting to put it aside, is incongruent where the client is

likely to pick up any ‘fakeness’ . It is argued that the client will be likely to become aware of the emotion in the therapist, either in the therapist’s body language, words used or even the tone of voice so any attempt to hide it from the client is futile and likely to create a barrier.

Anxiety was experienced by all the participants and was linked to different aspects and various stages of the process. One participant described her anxiety in terms of her terror if she failed to keep her client safe regarding severe self-harm and suicide risk. A second participant also mentioned suicide risk as a major feature in terms of their anxiety. Some studies suggest that there is an increased risk of suicide with clients who frequently self-harm (Alper & Peterson, 2001; Cuellor & Curry, 2007). Cooper, Kapnur, Webb, Lawlor, Guthrie and Machway-Jones (2005) support this argument and their study found that there was a 30-fold increase of suicide risk with people who self-harm compared to those who do not, therefore reinforcing the two counsellors’ fears in this present study concerning the likelihood that the client may attempt suicide. However, not all researchers agree with this stance and some argue that there is a clear distinction between intentional self-harm and suicide (Favazza, 1996). Suyemoto (1998) established what she called an ‘anti-suicide model’ of self-harm and argued that this behaviour actually staves off suicide in the client.

Anxiety can be equated to “intense fear or dread” (Universal Dictionary, 1986, p78) and Fickl (2007) in Spandler & Warner, 2007) suggests that therapists often experience fear when working with self-harming clients which can be connected to loss of control in the process when clients continue to self-injure. Over 20 years ago,

Favazza (1987) described how a 'promising treatment' can reach a 'stalemate' or an end due to both client and therapist not being able to reduce or stop the self-harm. However, not all theorists view the counsellor's anxiety as being detrimental to the process. Alternatively, Walsh (2006) argues that anxiety or fear can be useful in a therapeutic relationship as it can be "transformed into positive attentiveness" (p225) so that the therapist becomes alert to danger and such hyper-vigilance enabling any risk assessment of extreme self-harm or suicide threat. This notion does seem to be applicable to participant 5 in this present study, whose own terror had the impact of her being acutely focused on any risk to her client. However, I would question the longer term impact on the counsellor if the transformation process is not complete and the therapist is left with overwhelming personal anxiety resulting in a high personal cost to them.

Anger and frustration were experienced by two participants and Participant 2 described how she felt extremely angry in relation to medical model interventions which she saw as detrimental to the counselling process. The example she gave was a psychiatrist who administered Electro-Convulsive Therapy (ECT) over 15 months to one of her clients who had stopped self-harming. This treatment involves passing an electric current briefly through electrodes placed on a patient's head to bring on a convulsion. In the document 'Essence of Care' by the Modernisation Agency:NHS (http://www.modern.nhs.uk/ accessed June, 2010) Factor 2 identifies best practice for clients with mental health needs who self harm and stipulate that ECT could be considered. Billings (2009) suggests that ECT is appropriate for major depression, even though there is a risk that short-term memory may be affected. However, it can be questioned how helpful such interventions are in terms of treating

self-injury. In a survey carried out by the Mental Health Foundation (1997), 88% of the sample comprising of clients who self-harm, said they would prefer talking therapy than treatments such as ECT, so the foundation endorsed a more holistic approach to treatment. Although this survey was completed over 10 years ago, such medical interventions are still implemented today. For this participant in the present study, her anger, which she described as *'being livid'*, stemmed from the client's progress not being viewed as legitimate by a fellow professional , which she believed had the effect of undermining the work done in counselling. This participant went on to describe how clients who self-harm are treated terribly and often without compassion in Accident & Emergency which resulted in her feeling angry. Hopkins (2002) support this claim and their research suggests that health professionals had negative attitudes towards patients who intentionally self-injure, as nurses in this study were found to perceive these patients as disrupting the function of the busy medical admissions departments.

Another participant described her frustration in terms of her feeling impatient when a client refuses to change and continues to self-harm. Walsh (2006) suggests that anger can be transformed into a helpful response if it is used to help the client to "strategically fight the problem" (p225). Sutton (2006) takes a different view on therapist frustration. She suggests, the counsellor experiencing this emotion may lead to them attempting to rush the client through the process before they are ready, which can be detrimental to their progress.

Another sub-category related to impact was 'Affecting counsellor self-confidence' when first working with self-harm. Three participants reported that when they first

began working in the field of self-injury the challenging work had affected their self-confidence in a negative way. With one indicating how his self-confidence was so affected initially, that he felt it necessary to refer the client.

However, not all counsellors identified this impact. The two other participants reported that such work had not undermined their self-confidence with one participant saying that she had worked long and hard to hold on to her self-confidence in terms of her professional practice and this came across during the interview as a conscious decision on her part not to allow this to affect her in this way.

In terms of other impact on the therapist, participants reported some idiosyncratic effects, such as being thankful that they had had a happy, stable life compared to her clients who had self-harmed and such trauma experienced by clients as being 'a driver' for such work. For another participant the impact involved tapping into his own 'childhood pain', yet had contributed to his continuing 'acceptance of people generally' and this was seen as a real positive outcome of such work.

The second category was identified as 'Necessary requirements of the counsellor when working with self-harm'. Various factors included the need to avoid becoming overwhelmed, not react with panic and to be a robust enough container. This requirement involved the need to put aside powerful responses to self-harm such as shock, as expressing this emotion to the client was viewed as detrimental to the process. I believe it would be necessary to process such responses so it does not have a detrimental impact on the counsellor which would likely have repercussions for the counselling process. Spiers (2001) discusses the necessity of adequate

supervision in terms of the counsellor experiencing such intense emotion and deems this necessary so the therapist can avoid unhelpful responses such as rescuing or avoidance. Similarly, with regard to the present study, it was thought that counsellors should not react with panic when facing self-harm or the threat of suicide by their client. Shock and panic can be associated with the therapist's fear and Fickl (2007) stipulates that appropriate supervision and training is crucial for the counsellor so they can stay grounded and less controlled by their fear in the session with the client.

The need to communicate the longer term effects of the self-harm in relation to scarring and its wider social impact was considered essential, while also avoiding placing self-harm in the centre of the process which one participant described as a risky strategy. In fact, four participants were in agreement in terms of not focusing on the self-harm in the counselling session. However in contrast, two participants believed it was necessary to focus on the issue of self-harm and confusingly one participant appeared to take a contradictory stance stating there was a requirement to focus on the self-harm, but later in the interview saying there was a need not to focus on it.

For three participants, risk was a significant feature, with one describing how monitoring risk was a necessary requirement stating,

> *'there's always going to be a safety issue...it would feel like collusion letting them talk about it without...(*having the goal) *to check out whether the client is...suicidal..or can get*

immediate care'.

The third category of the 'Counsellor having an agenda for change to stop the self harm and this being either explicit or implicit was communicate by all five participants. Two appeared to have an explicit agenda for change in stopping the self-harm and communicated this to the client. Whilst the other three participants appeared to have an implicit agenda to stop the self-harm and although not stating this to the client, it was explored in supervision. One of the participants said,

> *'as a long term coping strategy it tends to peg people into a corner...and I don't want to be trapped in a situation where...nothing ever changes..and I wouldn't want that for the client either'*.

This participant appeared to come to some realisation during this interview and shared her new insight into her having an agenda for change.

There is a wide range of literature suggesting that therapists having an agenda to stop the self-harm, is common (Scott, Nelson and Gruenbaum, 1971; Pitman and Tyrer, 2008). Walsh (2008) takes a similar stance and argues that counsellors tend to put a lot of pressure on clients to stop self-harming suggesting they may communicate this pressure by praising the client when they say they have stopped and showing disappointment or frustration when they do not or relapse, giving a strong expectation to cease self-harming. Walsh makes the point that a client may react "by feeling misunderstood, resentful and feel like a failure" (p122) with such an

attitude, being detrimental to progression. This could result in the client behaving in a deceptive manner so as to get praise, even saying that they have not self-harmed when they have.

As previously discussed in this dissertation, research in the past predominantly linked self-harm to psychopathology with some more contemporary research (Alper and Peterson, 2001; Beasley, 2000) still holding with this idea. Matsumoto, Yamaguch, Takeshi, Okada, Yoshikawa and Hirayasu (2005) link intentional self-harm with dissociative disorder. Mangnell (2008) suggests that a "self-harm personality profile" (p179) has emerged and the Diagnostic and Statistical Manual of Mental Disorders 4th Edition-Text Revision (DSM-IV-TR:APA, 2000) associates it with underlying pathology as a symptom of Borderline Personality Disorder" . Kilty (2006) argues that there is a problem with identifying self-harm as a mental disorder which could lead to the 'medicalisation and psychiatrisation' of the problem which would likely take away the person's agency in terms of their care.

However many more modern day practitioners and researchers view self-harm as a legitimate coping mechanism which is not necessarily linked to an underlying mental disorder (Harris, 2000, Hogg, 2001). In this present study four participants resisted any label in terms of mental health and self-harm. However, one participant did link it to Borderline Personality Disorder.

Referring to past and current research, it is widely acknowledged that self-harm is a complex phenomenon with different views on whether it is linked to underlying pathology or not, whether there should be an agenda for change to stop the self-

harm or to aim to respect and accept the client's autonomy to self-injure, whether it is a legitimate coping or a maladaptive coping mechanism. Such conflicting messages are likely to be confusing for any counsellor working with a client who intentionally self-harms and Klonsky and Muehlenkamp (2007) describe how "clinicians are perplexed and uncertain about the best way to proceed in treating the behaviour" (p1053). In relation to the present study, three participants saw progression being related to a 'decrease in the level of physical damage'. Therefore, it can be assumed that counsellors would be likely to have expectations for clients to stop this behaviour.

Progression identified by the `Client now using replacement strategies' to minimise self-harm was indicated by two participants. Walsh (2008) discusses how some negative replacement skills such as snapping an elastic band on the part of the body which is usually cut or burned can have a 'transitional function' in order to help a client progress towards stopping the self-injury. However, not all theorists believe such strategies are helpful and Conterio and Lader (1988) argue that such replacement behaviours should not be used as they are too closely associated with self-harm which may trigger a relapse and cause the client to become preoccupied with self-injury.

A further subcategory of progression was identified as affect regulation, where clients are now talking about and experiencing their emotions and four participants saw this as a feature of progression in the client. Research supports these findings as Andover, Pepper, Ryabchenko,Orrico and Gibb (2005) found that people who intentionally self-harm are likely to experience anxiety and emotional dysregulation.

Lundh, Karim and Quilisch (2007) use the adjective alexithymic, meaning people who struggle to identify and understand their emotions. Progression for such a person who self-harms, would involve some change in this characteristic in terms of developing an ability to talk about and express their feelings.

Another feature of progression was related to the 'client gaining insight into why they self-harm?' Gardner (2001) identifies self-harm as a symbol as well as a symptom. This researcher is of the Psychodynamic orientation and suggests that self-injury is a "defence against an underlying psychic conflict" (p95). This author suggests that the therapeutic aim should be to place the emphasis on the "verbal symbols – 'words' rather than physical symbols – 'wounds'' (p95). Gardner appears to view progression as the client gaining insight, with the help of the therapist facilitating the process of bringing unconscious material into conscious awareness and providing understanding.

In the present study all 5 participants said that `Progression is not simply about stopping the self-harm' with there being significant factors linked to progression such as understanding the repercussions of permanent scarring and the client taking control of the process. Feldman (1988) would support this stance and over 20 years ago cautioned against the therapist taking too much responsibility for the client and argued that such over-concern attempting to rescue, could culminate in regression in the client.

The next category identified was 'Counsellors' perceptions of why people self-harm?' Although this was only indirectly linked to the focus of inquiry, all 5 participants

shared their views on why clients intentionally self-harmed so it seemed appropriate to include it. There seemed to be varied opinions on this which included antecedents to self-harm such as, despair, overwhelming feelings, wanting some peace, abuse driven, not having an identity, feeling invisible, to moderate their feelings, for punishment, bullying, Border-line Personality Disorder, self-disgust, self-dislike, sexual abuse, feeling like they are a bad person, it being like their own hug and the physical pain taking away the emotional pain. There is an abundance of research supporting these findings (Meninger, 1938; Favazza, 1989; Alderman, 1997; Harris, 2000; Hogg, 2001; Huband & Tantam, 2004; Matsumoto et al, 2005; Kilty, 2006; Walsh, 2006; Spandler & Warner, 2007; Klonsky & Muelankamp, 2007; and Mangnall, 2008).

A sub-category here included the 'counsellor perceiving self-harm as a coping mechanism' and all 5 participants said they believed it to be a coping mechanism which gives the client some sort of relief. Kilty (2006) makes the distinction between self-harm occurring with an underlying mental health condition and self-harm used as a coping mechanism. He goes on to say how it is a complex phenomenon with many causes and there being a need to view it as a coping method with more holistic approaches in the helping professions when working with clients who intentionally self-harm. Foster and May (2003) writing from a feminist standpoint argue that self-harm is about 'methods of coping and surviving' and not about 'dysfunction or mental illness' (p77). Kilty (2006) argues that such medical interventions described as 'psychiatrisation, infantilizes' the person, in the sense of making the assumption that 'we know what is best for them' (p165) and what is needed is a far more client-focused approach of attempting to understand the self-harm from the client's perspective.

Three participants in the present study said they work alongside the client and do not focus on the self-injury unless the client does. Craigen and Foster (2009) support this approach, as they found that clients did not like the counsellor focusing on the self-harm. One participant in their study said it was more helpful to focus 'on the issues beneath her self-injury which she referred to as her underlying stuff' (p85). Similarly Mearns and Schmid (2005) suggest that the Person-Centred Counsellor may not focus on the behaviour or problem such as self-harm, as to do this would be to collude with a client's 'self-protective processes'. They argue that to relate at depth, the therapist needs to be aware that "it is easier to relate to a problem than a person, particularly a hard-to-reach person" (p257) and the therapist should aim to avoid falling into this trap. One participant in this present study who works with clients who have experienced trauma such as sexual violence and childhood sexual abuse said she does not focus on the self-harm, but instead, what has caused it. The goal of helping the client to explore their trauma in depth was important here so that they gain understanding as to why they self-injured. This approach is in line with Trauma-focused therapy (Schnurr, Friedman and Foy, 2003) and by exploring the traumatic material, along with the thoughts, feelings and meanings associated with it, is viewed as a way of processing the trauma resulting in a reduction in the need to self-harm.

Counsellors differ in their views as to whether self-harm should be the focus in the therapeutic encounter and whether self-injury is a legitimate coping method (Spandler and Warner, 2007) or an "addictive maladaptive coping cycle of pain, relief, shame and self-hate" (Hicks and Hinck, 2007, p408). Whatever stance a

counsellor takes will undoubtedly have an impact on how they work with a client who self-injures, with that approach being either client-centred or more directive in nature.

Considering the variation in the characteristics of the participants in this study and specifically focusing on the issue of gender, there were four women in the study and one man. Interestingly, the male was the only participant who did not say that progression was linked to affect regulation, with the client now being able to talk about their feelings. This may be an area for future research and a larger sample could investigate gender difference in terms of perceptions of client progression. In fact, the male participant in the present study focused on the client gaining an insight into why they self-harm as an indication of progression. Research by Bowen and John (2001) suggested that professionals working in the field of Mental Health continued to find intentional self-harm challenging and argued that there was a gender bias with regards to assessment and in decisions regarding treatment. They state, “Differential gender biases in the nosology of comorbid conditions, psychodiagnosis, and treatment decisions are identified” (Bowen and John, 2001, p357). With respect to the therapeutic approach and the time since counselling a client who self-harmed of the participants, this appeared to be less influential on findings and there was no perceived difference in relation to the intensity of experience, with the interviewees appearing to talk at ease in response to the researcher’s questions.

Conclusion.

I established four 'outcome propositions' (Maykut and Morehouse, 1994) from investigating counsellors' perceptions of client progression when working with clients who intentionally self-injure and the impact such work has on the therapist. The first outcome proposition identified,

'The counsellor experiences intense emotion when counselling clients who intentionally self-harm, including shock, sadness, anxiety, anger and frustration'.

Previous research (Favazza, 1989; Alderman, 1997; and Walsh, 2006) supports these findings and agree there is a significant impact on the counsellor, arguing that self-injury is the most disturbing of behaviours facing counsellors (Gamble, Pearlman,Lucca, Allen 1994). Gardner (2001) suggested that "even the most hardened "(p142) of practitioners found repeated self-harm extremely daunting and frustrating. More recent research by Hoffman and Kress (2008) also support this stance and suggest that counsellors working with clients who intentionally self-injure "have strong personal reactions and struggle with how to proceed so as to minimise client risk and best help the client" (p97).

The second outcome proposition is,

'Perceptions of progression vary, with counsellors having an agenda for change to stop the self-harm,

married with the seemingly contradictory attitude of respecting the client's autonomy when using self-harm as a coping mechanism'.

Gardner (2001) describes how some literature seems to have an implicit message almost "advocating a woman's right to cut and injure herself" (p141) by accepting self-injury as a way of coping with overwhelming feelings. She goes on to stress the importance of attempting to try and understand the client's suffering in order for transformation to occur. However, it could be argued that transformation as part of the counselling agenda whether it exists in the form of a goal, an expectation or a hope is linked to having an agenda for change.

In terms of perceived progression varying, various themes were identified, including cessation of self-injury, a decrease in the level of physical damage, the client beginning to use strategies to minimise the self-injury, affect regulation and clients gaining an insight into why they self-harm. Although all participants said that progression was not simply about stopping, they also had either an explicit or implicit agenda for change. The conflict between these two aspects, concerned the uneasy state of trying to achieve a balance between respecting the clients right to self-harm as a coping mechanism and encouraging them to move towards stopping, creating a tension between the ethical principles of 'Beneficence' and 'Autonomy' (BACP, 2009).

As referred to in the literature review, I did locate research on cessation of self-harm, harm minimisation, affect regulation and the client gaining insight into why they self-

injure which could be associated with progression, yet there was no definitive link to perceptions varying which could be identified. However, the present study specifically refers to the variation in counsellors' perceptions of client progression, highlighting this as a feature.

The third outcome proposition is,

'There appears to be many contradictions in terms of the process and counsellors struggle to manage the tensions between these multiple dualities`.

Such dualities include,

- Counsellors indicating there is a requirement not to focus on the issue of self-harm so as to keep the counselling session agenda free but also stating a need to focus on it. This involves the uneasy task of the counsellor avoiding placing it in the centre of the process but at the same time not shying away from it.
- Self-harm being perceived as a maladaptive coping mechanism but also a legitimate coping method.
- Self-harm being linked to an underlying mental health disorder and not linked to psychopathology.
- Self-harm being linked to an increase in suicide risk whilst at the same time being considered as an anti-suicide model staving off any suicide threat.

Other seemingly conflicting dualities centred on perceptions of progression. Two views on progression could be linked directly to stopping the self-harm including a reduction in the physical damage and the client employing strategies to minimise the self-injury. The other views on progression were not directly linked to the physical act of self-harm and included affect regulation, the client gaining an insight into why they self-injure and it not simply being about stopping. Here there was overlap for all participants between these different dimensions on progression. Each participant regarded progression as being partly about minimising the physical act but also associated it with other aspects which did not directly link to the physical act of self-injury. How significant a counsellor may judge each aspect of progression to be, may serve to create confusion in terms of the process. For example, if a counsellor views both a reduction in physical damage and affect regulation as features of progression, would the main goal of the therapy be focused on helping the client to talk about their feelings or working towards stopping the self-injury? Even if it is a combination of both, I wonder how influential the counsellor's individual beliefs are in directing the process which is likely to affect their capacity in respecting client autonomy to use self-injury as a coping mechanism or in monitoring safety in terms of self-injury.

There also appears to be wider social expectations on the counsellor in terms of working with self-harm. The client's family members or other medical professionals appear to perceive the goal of therapy as stopping the self-injury (Sutton, 2006). However, a counsellor may take an alternative view and perceive self-injury as only part of the problem, therefore avoiding placing self-injury at the centre of the process. I would suggest that this may serve to exacerbate the counsellor's anxiety

especially if the client continues to self-injure despite counselling. Sutton (2006) suggests how therapists “feel weighed down by responsibility and accountability” (p287) from outside expectations to stop the self-harm.

However, with regards to the counsellor experiencing such tensions relating to the ambiguous nature of self-harm, I was unable to locate any research which specifically identified this viewpoint. Therefore, this study suggests a link to therapist anxiety which has not previously been addressed in the literature. .

The fourth and final outcome proposition identified,

‘There are challenging, yet necessary requirements of the counsellor when working in this field’.

There is a requirement to put aside intense feelings such as shock, therefore not communicating this to the client. It seemed important that the counsellor was not overwhelmed by the self-harm, needed to be a robust enough container and to acknowledge the client’s scars or a suicide attempt without showing fear.

The need to take a client-centred approach (Rogers,1957) was identified in the study. Suggesting the importance of ‘staying with’ the client in the process and avoid placing self-harm in the centre. However, there was some ambiguity in relation to this aspect as it was also suggested that there is a need to direct the process at various times to gain sufficient focus. One particular view involving the need to ask

questions about the self-harm was interpreted as not communicating the risks to the client would feel like collusion.

There was also a requirement to accept the self-injury as part of the client's journey but at the same time, making the client aware of the social impact of permanent scarring. A requirement which was seen as essential was to check out safety in terms of the client looking after their wounds. . Again there are apparent contradictions in these requirements such as not having self-harm as the focus, but also checking out the safety and communicating the social impact of scarring. Similarly, accepting self-harm as a coping mechanism and teaching the client to take care of the wounds, yet having an agenda for change may have an implicit message of advocating self-injury on one level but also communicating, even implicitly, an expectation to stop on another level. Therefore, it is likely that this would create some anxiety in the counsellor struggling to achieve a balance in attempting to meet these requirements and possibly confusion in the client in terms of therapist acceptance and non-acceptance.

Thirty years of research has not appeared to have addressed the confusion concerning the issue of self-harm and has raised many more questions than provided answers. This includes questions such as, is self-harm linked to psychopathology? Is self-harm directly linked to suicide? Is self-harm a maladjusted or legitimate coping mechanism? Should the goal be about stopping the self-harm or in respecting the client's autonomy to use self-injury as a legitimate coping method? Which is more significant in terms of progression: cessation of self-harm, a

reduction in physical injury, affect regulation or the client gaining insight? It appears, as a profession we are no further along in terms of firm answers.

This study suggests that counsellors continue to struggle in managing the tensions between the many contradictions and multiple dualities, which only serve to aggravate the therapist's anxiety. In summary, intentional self-harm is a complex phenomenon with ambiguity relating to theoretical understanding and establishing the most useful therapeutic approach. Opinions and research findings have given no clear answers which has implications for any counsellor working in this field. The hope is that future research, especially within the counselling profession and more specifically within the Person-Centred tradition would provide an additional perspective. As such, greater variation in the orientations of researchers investigating the issue of intentional self-harm, would contribute to a more complete understanding of the subject. In particular, a topic relating to the ambiguous nature of self-harm which has implications for counsellor anxiety, could be developed further. I believe it is necessary to incorporate the complexity of this phenomenon and acknowledge that there is no one cause, no one approach and no one way of viewing progression which I hope may lead to a more holistic appreciation. Thus, such ambiguity integrated into any theoretical understanding may contribute in some way towards reducing therapist anxiety by communicating there is more than one way of conceiving the issue and working with the problem.

References

Alderman, T. (1997). *The scarred soul: Understanding and ending self-inflicted Violence.* Oakland, CA: New Harbinger.

Alper,C., and Peterson, S. (2001). Dialectic behaviour therapy for patients with Borderline Personality Disorder. *Journal of Psychosocial Nursing*. 39(10), 38-45.

American Psychiatric Association (1980). Diagnostic and statistical manual of mental Disorders. (3rd ed.). Washington, DC.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental Disorders.* (4th ed., text rev.). Washington, DC.
Andover, M.S., Peper, C.M., Ryabchenko, K.A., Orrico, E.G., andGibb, B.E. (2005). Self-mutilation and Symptoms of depression, anxiety and borderline personality disorder. *Suicide and Life-Threatening Behaviour.* 35, 581-591.

Andover, M.S., Peper, C.M., Ryabchenko, K.A., Orrico, E.G. and Gibb, B.E. (2005). Self-mutilation and symptoms of depression, anxiety and borderline personality disorder. *Suicide and Life-Threatening Behaviour.* 35, 581-591.

Arnold, L. (1995). *Women and Self-Injury: a survey of 76 women.* Bristol. Bristol Crisis Service for Women.

Beasely, S. (2000). Deliberate self-harm in medium security. *Nursing Management*, 6(8),29-33.

British Association for Counselling and Psychotherapy (2009). *The BACP Ethical Framework for Good Practice.*

Billing, D.M. (2009). *Lippincotts Content Review for NCLEX-RN.* Philadelphia. Wolters Kluwer Health/Williams and Wilkins.

Bond, T. (2004). *Researching Counselling and Pychotherapy.* Leicester. BACP.

Bowen, A.C.L. and John, A.M.H. (2001). Gender differences in presentation and conceptualization of adolescent self-injurious behaviour: implications for therapeutic practice. *Counseling Psychology Quarterly*. 14(4), 357-379.

Brinkmann, S. And Kvale, S. (2008). Ethics in qualitative psychological research, in C.Willig and W. Stainton Rogers (eds). *The Sage Handbook of Qualitative Research Psychology*. London:Sage.

Brown, L.S. and Bryan, T.C. (2007). Feminist therapy with people who self-inflict violence. *Journal of Clinical Psychology.* 63, 11, 1121-1133..

Brumberg, J. J., (2006). Are we facing an epidemic of self-injury? *The Chronicle of Higher Education,* 53,6-13.

Conterio, K., and Lader, W. (1998). *Bodily Harm.* New York: Hyperion Press.

Cooper, J., Kapnur, N., Webb, R., Lawlor,M., Guthrie, K., Machway-Jones, K. (2005). Suicide after deliberate self-harm. A 4-year cohort study. *American Journal of Psychiatry.* 162(2),297-303.

Craigen, L.M. and Foster, V. (2009). "It Was Like a Partnership of the Two of Us Against the Cutting": Investigating the Counselling Experience of Young Adult Women Who Self-Injure. *Journal of Mental Health Counseling*. 31(1), 76-94.

Cuellar, J. and Curry, T. (2007). The prevalence and comorbidity between delinquency, drug abuse, suicide attempts, physical and sexual abuse and self-mutilation among delinquent Hispanic females. *Hispanic Journal of Behavioural Sciences.* 29(1), 68-78.

Deiter,P.J. and Pearlman, L.A. (1998). Responding to self-injurious behaviour. In R.M. Kleespies (ED.). *Emergencies in mental health practice: Evaluation and management*. (235-257). New York Guildford Press.

Denscombe, M. (2007). *The Good Research Guide for Small Scale Research* Projects (3rd edition). Maidenhead. Open University Press.

Denzin, N.K. and Lincoln, Y.S. (2000). (eds.). *Handbook of Qualitative Research* (2nd ed.).Thousand Oaks. CA. Sage.

Dunscombe, J. and Jessop, J. (2002). 'Doing rapport' and the ethics of 'faking Friendship': In M. Mauthner, M. Birch, J. Jessop and T. Miller (eds). *Ethics in Qualitative Research in Psychology*. London: Sage.

Duperouzel, H., & Fish, R. (2007). Why couldn't I stop her Self-Injury: the views of staff and clients in a medium secure unit. *British Journal of Learning Disabilities,* 36,59-65.

Dusty Miller (2002). Addictions and Trauma Recovery: An Integrated Approach. *Psychiatry Quarterly. 73* (2), 157-170.

Elliott, R., Fischer, C.T. and Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields, *British Journal of Clinical Psychology,*38: 215-29.

Elmes, D.G., Kantowitz, Z.H. and Roediger, H.L. (1995). Research Methods in Psychology, 5th Edition St Paul: West Publications Company.

Favazza, A.R. (1987). *Bodies under siege: Self-mutilation in culture and society.* Baltimore. MD: Johns Hopkins University Press.

Favazza, A.R. and Conterio, K. (1988). The plight of chronic self-mutilators. *Community Mental Health Journal.* 24, 22-30.

Favazza, A.R. (1989). Why Patients Mutilate Themselves. *Hospital and Community*

Psychiatry. 40:2 137-145.

Favazza, A.R. (1996). *Bodies wider siege: Self-mutilation and body modification in culture and psychiatry* (2nd ed). Baltimore, MD: Johns Hopkins University Press.

Feldman, M.D. (1988).The Challenge of Self-Mutilation: A Review: *Comprehensive Psychiatry.* 29 (3), 252-269.

Fickl, T. (2007). Chapter 6, p91-103: In Spandler and Warner (2007). *Beyond Fear and Control: working with young people who self-harm.* Ross-on-Wye. PCCS Books.

Figley, C.R. (1995a). 'Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview': In C.R. Figley (ed). *Compassion Fatigue: Coping with Secondary Stress Disorder in Those Who Treat the Traumatised.* New York: Brunner/Mazel.

Fish, R.M. (2000). Working with people who harm themselves in a forensic learning disability service*. Journal of Learning Disabilities.* 4(3),193-207

Foster, V. and May, K.M.(2003). Counseling women from feminist perspectives. In N. Vacc, S. DeVaney and J. Brende (Eds.). Counseling multicultural and diverse populations: Strategies for practitioners. (163-187). New York. Brunner-Routledge.

Gamble, S.J., Pearlman, L.A., Lucca, A. M., and Allen, G.J. (1994). Vicarious Traumatisation and burnout among Connecticut psychologists: Empirical Findings. Paper presented at the annual meeting of Connecticut Psychological Association. Waterbury. CT. www.thefreelibrary.com/Students+who+self-injure%3A+School+counselor+ethical+and+legal...-a0157032933 accessed July 2010.

Gardner, F. (2001). Self-harm; a psychotherapeutic approach. London. Routledge; Taylor and Francis Group.

Geertz, C. (1973). *The Interpretation of Culture: Selected Essays.* New York. Basic Books.

Glaser, B.G. and Strauss, A. (1967). *The Discovery of Grounded Theory.* Chicago. Aldine.

Graff, H. and Mallin, R. (1967). The syndrome of the wrist cutter. *American Journal of Psychiatry*, 124(1) 36-42.

Gratz, K.L. (2007). Targeting emotion dysregulation in the treatment of self-injury. *Journal of Clinical Psychology*: In Session. 63,1091-1103.

Hansen, J.T. (2002). Postmodern implications for theoretical integration of counseling orientations. *Journal of Counseling & Development,* 80, 315-321.

Harris, J. (2000). Self-harm: Cutting the bad out of me. *Qualitative Health Research*. 10(2),164-173.

Harrison, D. (1994). *Vicious Circles, an Exploration of Women and Self-harm in Society.* London.GPMH Publications.

Harrison, D. & Sharman, J. (2005). Understanding Self-harm. Mind Publications. http://www.mind.org.uk/Information?Booklets?Understanding?Understanding+self-harm.htm accessed July 2010.

Hawton, K., Townsend, E., Arensman, E. (1999). Psychosocial and pharmacological treatments for deliberate self harm. *Cochrane Database of Systematic Reviews,*4.

Hicks, K.M. and Hinck, S.M. (2008). Concept analysis of self-mutilation. *Journal of Compilation.* (2008), p408-413. Blackwell Publishing Ltd.

Hoffman, R.M. and Kress, V.E. (2008). Client Non-Suicidal Self-Injurious Behaviour: Considerations for Clinical Supervisors. *Clinical Supervisor.* 27(1), 97-110.

Hogg, C. (2001). Should nurses always intervene when patients self-harm? *NursingTimes*. 97, 49.

Hopkins, C. (2002). But what about the really ill, poorly people? (An ethnographic study into what it means to nurses on medical admissions units to have people who have harmed themselves as their patients. *Journal of Psychiatric and Mental Health Nursing*. 9(2),147.

Huband, N. and Tantam, D. (2004). Repeated self-wounding: Women's recollection of pathways to cutting and of the value of different interventions. *Psychology and Psychotherapy: Theory Research and Practice.* 77, 413-428.

James, M. & Warner, S. (2005). Coping with their lives – women, learning disabilities, self-harm and the secure unit: a Q-methodological study. *British Journal of Learning Disabilities*, 33,120-127.

Johnston, A., Cooper, J. and Kapnur, N. (2006). Exploring the Relationship Between Area Charaqcteristics and Self-Harm. Old and New Approaches. *Crisis.* 27 (2) 88-91.

Kilty, J.M. (2006). Under the Barred Umbrella: Is there Room For a Women-Centered Self-Injury Policy in Canadian Corrections? *Criminology and Public Policy.* 5(1), 161-182.

Klonsky, E.D. (2007). Non-Suicidal Self-Injury: An Introduction. *Journal of Clinical Psychology*: In Session. 63, (11), 1039-1043.

Klonsky, E.D. and Muehlenkamp, J.J. (2007). *Self-Injury: A Research Review for the Practitioner.* 63, (11), 1045-1056.

Krueger, R.A. (1988). *Focus Groups: A Practical Guide for Applied Research*. London. Sage.

Kvale, S. (1983). The qualitative research interview: a phenomenological and hermeneutical mode of understanding. *Journal of Phenomenological Psychology.* 14 (2), 171-96.

Laye-Gindhu, A. and Schonert-Reichi, K.A. (2005). Nonsuicidal self-harm among community adolescents: Understanding the "Whats" and "Whys" of Self-Harm. *Journal of Youth and Adolescence.* 34(5), 447-457.

Liebling, H., Chipchase, H. and Velangi, R. (1997). Why do women harm themselves? Surviving special hospitals. *Feminism and Psychology*. 7(3), 427-37.

Lincoln, Y. and Guba, E. (1985). *Naturalistic Inquiry.* Beverley Hills, CA: Sage.

Loftland, J. (1971). *Analysing Social Settings.* Belmont. CA: Wadsworth.

Lundh L.G., Karim, J., and Quilisch, E. (2007). Deliberate self-harm in 15-year old adolescents: A pilot study with a modified version of the Deliberate Self-harm Inventory . *Scandinavian Journal of Pschology,* 48, 33-41..

Mangnall, J. (2008). A Literature Review of Deliberate Self-Harm. *Perspectives in Psychiatric Care*. 44(3), 175-184.

Matsumoto, T., Yamagechi, A., Takeshi, A., Okada, T., Yoshikawa, K., Hirayasw, Y. (2005). Characteristics of self-cutters among male inmates: Association with bulimia and dissociation. *Psychiatry and Clinical Neurosciences*. 59 , 319-326.

Maykut, P. & Morehouse, R. (1994). *Beginning Qualitative Research: A Philosophic and Practical Guide.* London. The Falmer Press.

McCann, I.L. and Pearlman, L.A. (1990a). *Psychological Trauma and the Adult Survivor. Theory and Transformation.* New York: Brunner/Mazel.

McLeod, J. (1994). *Doing Counselling Research*. London: Sage Publications.

McLeod, J. (2003). Doing Counselling Research. (22nd edition). London: Sage.

Mearns, D and Schmid, P. (2006). Bing-With and Being-Counter: Relational depth: The challenge of fully meeting the client. *Person-Centred and Experiential Psychotherapies*. 5(4),255-265).

Menninger, K.A. (1938). Man Against Himself. New York. Harcourt Brace and Company.

Mental Health Foundation. (1997). *Knowing Our Own Minds: A survey of how people*

in emotional distress take control of their lives. Modernisation Agency: NHS. *Essence of Care*. http://www.modern.nhs.uk/ accessed June 2010.

Muehlenkamp, J.J. (2006). Empirically supported treatments and general therapy guidelines for non-suicidal self-injury. *Journal of Mental Health Counseling*,

Nafisi, N., & Stanley, B. (2007). Developing and maintaining the therapeutic alliance with self-injuring patients. *Journal of Clinical Psychology*: 63, 1069-1079.

National Institute for Health and Clinical Excellence (2004). *Self-Harm: the Short-Term. Physical, Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary Care.* Clinical Guideline 16, NICE.

Olfsen, M., Gameroff, M.J., Marcus, S.C., Greenberg, T. And Shaffer, D. (2005). Emergency Treatment of Young People Following Deliberate Self-Harm. *Archives of General Psychiatry,* 62: 1122-1128.

Pearlman, L.A. and Saakvitne, K.W. (1995a). *Trauma and the Therapist: Countertransference and Vicarious Traumatisation in Psychotherapy with Incest Survivors.* New York. W.W.Norton.

Pembroke, L. (1996). (ed.). *Self-harm: Perspectives from personal experience.* London. Survivors Speak Out.

Pengnally, N. (2008). Harm minimisation after repeated self-harm: development of a Trust handbook. *The Psychiatrist.* 32, 60-63.

Peplou, H.(1992). Interpersonal relations: a theoretical framework for application in Nursing practice. *Nursing Science Quarterly*, 5, 13-18.

Pitman A. and Tyrer, A. (2008). Implementing clinical guidelines for self-harm – highlighting key issues arisen from the NICE guidelines for self-harm. *Psychology and Psychotherapy: Theory Research and Practice.* 81(4), 377-397. British Psychology Society.

Popper, K.R. (1959). *The Logic of Scientific Discovery.* New York. Basic Books.

Reason, P. and Rowan, J. (eds). (1981). *Human Inquiry: A Sourcebook of New Paradigm Research.* Chichester: Wiley.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology. 21:2 95-103.*

Ross, S. and Heath, N. (2002). A study of the frequency of self-mutilation in a Community sample of adolescents*. Journal of Youth and Adolescence.* 31,67-77.

Rothschild, B. and Rand, M. (2006). *Help for the Helper: The psychophysiology of compassion fatigue and vicarious trauma. Self-care strategies for managing Burnout and stress.* London: Norton.

Sanderson, C. (2006). *Counselling Adult Survivors of Child Sexual Abuse*. (3rd ed.). London: Jessica Kingsley.

Sansone, R.A., Wiederman, M.W and Sansone, L.A. (1998). The Self-Harm Inventory (SHI): development of a scale for identifying self-destructive Behaviours and borderline personality disorder. *Journal of Clinical Psychology.* 54: 973-983.

Scott, H., Nelson, M.D. and Grunebaum, H. (1971). A Follow-Up Study of Wrist Slashers. *American Journal of Psychiatry.* 127(15) 81-85.

Schnurr, P.D., Friedman, M.J., Foy, D.W. (2003). Randomised trial of trauma-focused group therapy for post-traumatic stress disorder. *Arch Gen Psychiatry.* 60:481-488.

Sexton, L. (1999). Vicarious traumatisation of counsellors and effects on their Workplaces. *British Journal of Guidance & Counselling.* 27(3) 393-403.

Shapiro, S. (2008). Addressing Self-Injury in the School Setting. *Journal of School Nursing*, 24, 124-130.

Shaw, N. (2002). Shifting conversations on girls' and womens'self-injury: An analysis of the clinical literature in historical context. *Feminism and Psychology*, 12, 191-219.

Shaw, C. and Shaw, T. (2007). Chapter One.:*A Dialogue of Hope and Survival.* In Spandler, H. and Warner, S. (2007). Beyond Fear and Conrol: working with young people who self-harm. Ross-on-Wye: PCCS Books.

Shepperd, C. and Mcallister, M. (2003). CARE: A framework for responding therapeutically to the client who self-harms. *Journal of Psychiatric and Mental Health Nursing*. 10,442-447.

Slee, N., Arensman, E., Garnefski, N., Spinhoven, P. (2007). Cognitive-Behavioural Therapy for Deliberate Self-Harm. *Crisis: The Journal of Crisis Intervention And Suicide Prevention.* 28, 2, 175-182.

Spandler, H. and Warner, S. (2007). *Beyond Fear and Control: working with young people who self-harm.* Ross-on-Wye: PCCS Books.

Spiers, T. (2001). *Trauma: A Practitioner's Guide To Counselling*. East Sussex. Routledge.

Spinelli, e. (2005). *The Interpreted World*. London: Sage.

Stiles, W.B. (1993). Quality control in qualitative research. *Clinical Psychology Review.* 13. 593-618.

Sutton, J. (2005). *Healing the hurt within: Understand self-injury and self-harm, and*

heal the emotional wounds. (2nd edition). Glasgow: how-to--books.

Suyemoto, K. L. (1998). The functions of self-mutilation. *Clinical Psychology Review*. 18(5), 531-554.

Taylor, C. (1979). Interpretation and the science of man. In P. Rabinow and W. Sullivan (eds). *Interpretive Social Science: A Reader.* Berkeley. CA: University of California Press.

Turp, M. (1999). Encountering Self-Harm in Psychotherapy and Counselling Practice. *British Journal of Psychotherapy*, 15(3) 306-321.

Turp, M. (2003). *Hidden Self-harm: Narratives from psychotherapy*. London. Jessica Kingsley.

Universal Dictionary. (1986). Boston: Houghton Mifflin Company.

Walsh, B.W. (2008). *Treating Self-Injury: A Practical Guide.* London: The Guildford Press.

Weber, M. (2002). Triggers for self-abuse: a qualitative study. *Archives of Psychiatric Nursing. 16*,118-124.

White Kress, V.E. (2003). Self-injurious behaviours: Assessment and diagnosis. *Journal of Counseling & Development.* 81, 490-496.

Willig, C. (2008). *Introducing Qualitative Research in Psychology.* (2nd edition). Berkshire: Open University Press.

Woldorf, G. M. (2005). Collaborative Practice: Clinical Implications of the Paradox of Deliberate Self-Injury. Journal of Specialists in Pediatric Nursing, 10(4) 196-200

World Medical Declaration of Helsinki. (2000). Edinburgh: WMA. Accessed Feb 2009: www.wma.net/

vi. Appendices

Appendix 1

Epilogue

Before commencing this study my work with clients who intentionally self-injured was immensely challenging. I consistently questioned my approach in an attempt to find the most effective way of helping my clients. Yet, what do you say to a client who attends for counselling with a self-inflicted burn on her arm relating to her past abuse. Initially, I had to battle with my own disbelief; how could any emotional pain be so great that the immense physical pain of that burn be the better option? Not long later I became aware of the overwhelming emotional traumatic pain that often triggers such acts of self-injury.

I have experienced such emotions including shock, anxiety and frustration in response to such work and with the ambiguous nature of the phenomenon and the complex counselling process serving to add to the pressure on me to get it `right'. Although I attempted to 'stay with' my client allowing them to direct the flow of the session, I was also aware of my inner agenda for change; wanting the client to stop this behaviour but how do you say stop to a client who says "this is keeping me alive". Such words add weight to the argument for a person-centred approach with the counsellor resisting voicing their agenda for change.

Another, a young woman who turns up for her session with a bandage on her arm hiding a fresh scar approximately five inches long in a place where last week existed a smooth patch of unblemished soft skin. I wanted to scream "look what you are doing to yourself, please, please stop". Instead I remained calm and in a soft voice said, "a new cut?" You can talk about the self-harm, you can talk about the consequences of permanent scarring, you can talk about the underlying issues but if there is any movement towards stopping, this has to come from the client first expressing a desire to stop.

So how has completing this study impacted on me as a therapist working with self-harming clients? Hearing how other counsellors struggle in managing the various tensions with regards to the ambiguous nature of the counselling process has reassured me that I am not alone in experiencing anxiety and uncertainty when working with a client who intentionally self-injurers. With regards to the future, what approach will I take the next time a client enters my counselling room with the issue of self-harm? As always I will attempt to listen empathically, offer positive regard, I would not avoid the issue of self-harm nor the underlying problem, I would communicate risk factors, challenge when the need arises and if appropriate I would help establish replacement strategies depending on client need. However, my hope that they will express a desire to stop will also be present even if this is not expressed and if they continued with this coping method I would aim to stay in their frame of reference communicating respect and valuing their point of view. Such an approach will undoubtedly have a personal impact on me as I will struggle to manage the tension between respecting their autonomy and my agenda for change which I will endeavour to keep inside my own head.

Appendix 2

Literature Search

For the initial literature search I accessed a small number of journal articles including Scott, Nelson and Grunebaum (1971) and Favazza (1989) which gave an historical view on how practitioners worked with clients who intentionally self-harmed during that time. I then referred to a small number of contemporary research articles such as Aviva Laye-Grindiv and Schonet-Reichi (2005) and Huband and Tantam (2004) for comparison in terms of a more modern view of client progression. To hopefully gain some initial insight into the impact on the counsellor I referred to Sexton (1992) journal article on vicarious traumatisation. With regards to books on self-harm in the initial review I referred to a small range on each aspect of the study including Spandler & Warner,2007; Sutton,2005; Sanderson,2006; Rothschild & Rand, 2006; and Spiers, 2001. A further research publication was referred to by Arnold (1995) allied to the Bristol Crisis Services for Women which was a survey of 76 women who had experienced counselling who had engaged in self-injury. This particular research includes the topics of the functions served by self-injury and women's experiences of services who respond and support clients who self-injure including counselling. An additional resource included the researchers own personal library of Counselling and Psychotherapy Journals (BACP) dated from 2001 to the present (2010). This initial literature review enabled me to identify the specific areas of focus for this research study.

Table 1 - Specific areas of focus.

1	Historical Context – Client progression	1970 – 2000
2	Contemporary Context – Client progression	2007 – 2010
3	Impact on the Counsellor	2007 – 2010
4	Linking client progression to the impact on the counsellor	

Table 2 - Journals searched in the initial literature review

Journal	Article	Author/s	Date	Search	Identified area of interest
American Journal of Psychiatry 127:10 (81-85)	A Follow-Up Study of Wrist Slashers	Scott, H., Nelson,M.D., Grunebaum H.	1971	Accessed via British Library	Historical Perspective
Hospital and Community Psychiatry 40:2 (137-145)	Why Patients Mutilate Themselves	Favazza, A.R.	1989	"	"
Journal of Youth & Adolescence 34:5 (447-457)	Non-suicidal Self-Harm Among Community Adolescents: Understanding the "Whats" and "Why"? of Self Harm	Aviva Laye-Grindiv, Kmberly, A and Schonet-Reichi	2005	Chester library online e-search – Psychinfo	General Background material
Psychology and Psychotherapy: Theory, Research and Practice 77(413-428)	Repeated Self-wounding: Womens' recollection of pathways to cutting and of the value of different interventions	Huband,N & Tantam,D.	2004	British Psychological Society online journal library	Client progression
British Journal of Guidance and Counselling 27:3 (393-403)	Vicarious traumatisation of counsellors and effects in their workplaces	Sexton, L.	1999	Staffordshire University data base library	Impact on the counsellor

Table 3 - Books searched in the initial literature review

Author/s	Date	Book Title	Publisher
Rothschild, B. Rand, M.	2006	Help for the Helper: The psychophysiology of compassion fatigue and vicarious trauma. Self-care strategies for managing burnout and stress.	Norton publishers
Sanderson, C.	2006	Counselling Adult Survivors of Child Sexual Abuse	Jessica Kingsley Publishers
Spandler, H. & Warner, S.	2007	Beyond Fear and Control	PCCS Books
Spiers, T.	2001	Trauma: A practitioner's guide to counselling.	Routledge Taylor Francis Group
Sutton, J.	2005	Healing the hurt within: Understand self-injury and self-harm, and heal the emotional wounds.	How to Books Ltd.

For the final literature review I referred to a range of texts on self-injury and research. Table 8 below lists the 10 core texts used in the review(for a full reference see reference list).

Table 4 **Core Texts used in the final literature review**	
Author	**Title**
Denzin,N.K. & Lincoln,Y.S. (2000)	The Good Research Guide for Small Scale Research Projects (3rd ed)
Maykut,P.& Morehouse,R.(1994)	Beginning Qualitative Research: A Philosophic and Practical Guide
McLeod,J. (2003)	Doing Counselling Research
Rothschild,B and Rand,M. (2006)	Help for the Helper:The psychophysiology of compassion fatigue and vicarious trauma: Self-care strategies for managing burnout and stress
Sanderson,C. (2006)	Counselling Adult Survivors of Child Sexual Ause
Spandler,H & Warner,S. (2007)	Beyond Fear and Control: Working with young people who self-harm
Spiers,T. (2001)	Trauma: A Pracitioner's Guide to Counselling
Sutton,J. (2005)	Healing the hurt within: Understanding self-injury and self-harm and heal the emotional wounds
Walsh,B.W. (2006)	Treating Self-injury: A Practical Guide
Willig,C. (2008)	Introducing Qualitative Research: Psychology

Journal articles

Search strategy –publications from 1970-present day (2010)

This involved some physical search including the researcher's personal journal library, searching in Chester University Archive Library and Staffordshire University Library. The researcher also accessed the British Library Search to access some older journals which helped to set the subject of self-harm within an historical context. For the online search, searching strategies were used. Below are some examples of the electronic searches employed:

- Couns* and (self-harm or self-injury)
- Couns* and self-mutilation
- Psychotherapy and (self-harm or self-injury)
- Psychotherapy and self-mutilation
- Self-harm and counselling and impact
- Self-harm and self-injury and interventions
- Intentional and self-harm
- Intentional and self-injury
- Deliberate and self-harm
- Deliberate and self-injury
- Deliberate and self-mutilation
- Self-harm and recovery
- Self-mutilation and recovery

(Additional terms of 'progression' and 'impact' and 'self-injury and recovery' did not yield any specific results).
My search gave a wide range of journal articles for consideration. However the researcher could not find any research linking progression to the impact on the counsellor.

Table 5 - Full list of Research Journals referred to.

Counselling/Psychotherapy Journals:
American Journal of Psychotherapy
British Journal of Clinical Psychology
British Journal of Guidance & Counselling
Counselling & Psychotherapy Research
Counselling Psychology Quarterly
Psychology and Psychotherapy: Theory, Research and Practice
Other journals accessed from the field of psychology, psychiatry and nursing:
Aggressive Behaviour
American Journal of Psychiatry
Australasian Psychiatry
Australian and New Zealand of Psychiatry
Clinical Supervisor
Community Care
Comprehensive Psychiatry
Criminology Public Policy
Deviant Behaviour
Evidence-Based Mental Health
Hospital and Community Psychiatry
International Emergency Nursing
International Journal of Geriatric Psychiatry
International Journal of Mental Health Nursing
International Nursing Review
Journal of Clinical Nursing
Journal of compilation
Journal of Clinical Psychology
Journal of Forensic Sciences
Journal of Psychiatric & Mental Health Nursing
Journal of Youth & Adolescence
Scandinavian Journal of Psychology
The Journal of Child Psychology & Psychiatry

Please refer to the reference section for a list of the particular journal articles used in the dissertation.

Table 6- Where the researcher accessed the journal articles for this study.:

Physical Search	**Journal**
Researchers personal library	Counselling & Psychotherapy Research (2001-present
Staffordshire University Library	British Journal of Guidance & Counselling
British Library Search	American Journal of Psychotherapy American Journal of Psychiatry Comprehensive Psychiatry Hospital & Community Psychiatry
Online Data Bases	
PsycARTICLES	Various articles accessed
PsycINFO	"
InfoTrac Web	"
SocINDEX	"
Ingenta Connect	"
British Psychological Society (www.bps.org.uk)	Psychology Psychotherapy: Theory, Research and Practice – Various articles accessed
Chester University – Psycinfo PsycARTICLES	Wide range of articles accessed
Staffordshire University – PsycARTICLES Wiley Inter Science Psycinfo Science direct	"

Appendix 3: Advertisement (A4 Poster)

Appendix 4: Leaflet size advertisement (A5 size)

Appendix 5

Letter responding to potential participants

Researchers Contact details

Ref: Potential participants contact details

Date:

Dear .....,

Thank you for enquiry regarding the research for my Masters in Counselling Studies at Chester University. The aim of the study is to explore counsellors' perceptions of working with clients who intentionally self-injure. I intend to record the interview by using an audio digital recorder and to make a written transcript of the session.

At this stage I have enclosed an information sheet and a pre-interview questionnaire for you to complete and return at your convenience.

If you have any questions please feel free to contact me at the above address/email/phone number.

Thank you for your participation.

Regards,

Doreen Fleet.

Appendix 6

Information Sheet.

Aim

The purpose of this study is to explore counsellors' perceptions of working with clients who intentionally self-injure. In particular I aim to investigate therapists' perceptions of client progression and how such work impacts on the counsellor.

Benefits and Risks

I hope that participating in the research and sharing your experience of working in such a challenging field will give you the opportunity to join in the 'research conversation' (McLeod, 1994) which may have some bearing on developing knowledge within the counselling profession.

There are unlikely to be any risks involved in participating in this research, but a list of counsellors could be provided if necessary.

Interviews

Prior to arranging an interview I will ask you to sign a consent form so you can formally accept the invitation to participate in the research.

Once you have accepted, we can arrange an interview and I intend to travel to your choice of location or if preferable to you, give you the choice of carrying out the interview in my dedicated counselling room in Cheshire.

The interview is likely to take up to one hour and I will give you the opportunity to take part in a debriefing where you can ask any questions you may have.

Regarding informed consent, you will have the right to withdraw at any time during the research process.

Confidentiality

I will regard the information disclosed by you as confidential but within the boundaries of the BACP Ethical Framework. You are entitled to use a pseudonym to

protect your anonymity and I will avoid using your name on the audio tape or in written form. Data such as audio tapes and transcripts will be stored securely and will be destroyed by shredding after 5 years.

Criteria for inclusion in the study include:

- Over 5 years experience as a qualified counsellor.
- Experience of counselling clients who intentionally self-injure by cutting and/or burning.
- Ongoing counselling supervision.
- Access to a personal counsellor if needed.

Supervision

My research is supervised by Dr Rita Mintz at the University of Chester.

If you perceive a problem with the research and this is not adequately resolved by communication with the researcher, the supervisor may be contacted.

Thank you for taking part in this research study and I hope this will prove to be a positive experience for you.

Appendix 7

MA in Counselling Studies. University of Chester.

Pre-interview Questionnaire.

Dear……,

Thank you for responding to the advert requesting participants for my research study on 'counsellors' perceptions of self-injury'.

If you are in agreement could you please complete the questionnaire below and return it in the pre-paid envelope provided?

If you have any questions please do not hesitate to contact me on either:

Email – doreen.fleet@gmail.com Phone - xxxxxxxxxxxxxxxxxxx

d.fleet@staffs.ac.uk

Questionnaire. (Please circle)

1. What is your counselling approach?

Person-Centred Psychodynamic CBT Gestalt Other (please state)

2. How many years have you been qualified as a counsellor?

More than 5 years 4 years 3 years 1 year Less than 1 year

3. When did you last work with a client who self-injured by cutting or/and burning?

Currently Within 8 months More than 8 months ago More than 1 year ago.

4. Have you suffered from burnout/compassion fatigue within the last 3 months?

Yes No

5. Do you have ongoing counselling supervision?

Yes No

6. Do you have access to a personal counsellor?

Yes No (The researcher can provide a list if required)

Thank you for completing this form.

I am willing to be contacted with a view to taking part in an interview as part of your research.

Signature:----------

Name: Address:

Tel: Email:

Appendix 8

Letter to include participants

Researchers contact address

Date:

Participants contact address

Dear.....

Thank you for agreeing to take part in this research interview for my Masters in Counselling Studies at Chester University. The aim of the study is to explore counsellors' perceptions of working with clients who intentionally self-injure. I intend to record the interview by using an audio digital recorder and to make a written transcript of the session. Once I have the recording of the interview, I will hold this in a safe place with only myself having access to it and to code it with a number. Your name will not be used and only I will know your identity. I will also ensure that your name and identity will remain confidential and will not be associated with the written transcript and dissertation.

The information from the transcript will be used solely for the purpose of this research and you will be given the option of reviewing the transcript and have the right to request any section of the data to be removed from the transcript if you wish. Once the dissertation is complete, I will securely store the data and after 5 years destroy the audio recordings and the transcripts by shredding them. My supervisor is Dr Rita Mintz at Chester University who can be contacted if you perceive any problem which has not been adequately resolved with the researcher.

I have enclosed 2 consent forms for you to complete, one for your own records and the other for myself. If you are happy with these arrangements, please sign the consent forms and I wll collect my copy when we meet for the interview.

If you have any questions please feel free to contact me at the above address/email/phone number.

Thank you for your participation.

Regards,

Doreen Fleet.

Appendix 9

Letter for not selected

Researchers contact address

Date:

Contact Address.

Ref: MA Research - Completed Questionnaire

Dear.....

Thank you for completing and returning the questionnaire for my research into Counsellors' perception of self-injury.

At this stage I will not need to interview you but with your permission I will hold your completed questionnaire on file confidentially and may contact you again later with a view to an interview. On completion of the research I will destroy your completed questionnaire.

Thank you.

Regards,

Doreen Fleet

Appendix 10

Table 8: Interview questions and sub-questions

	Interview questions: 1, 2, 3 **Sub-questions: 1a,2a,3a**
1	Could you talk about your work with clients who intentionally self-injure?
1a	What are some of the recurring themes that come up more often?
2	What are your perceptions about moving forward in terms of self-injury?
2a	What indications do you feel signal that your client is healing?
3	Can you talk about how such work has impacted on you as a person?
3a	When your client has continued to self-harm despite counselling, does this have an impact on you?

Appendix 11

Interview Guide

Interview Guide for Participants.

Thank you for agreeing to record this research interview related to my Masters in Counselling Studies at Chester University.

I am interested in counsellor's perceptions related to their experience of counselling clients who intentionally self-injure and intend to ask you some questions to help you explore your views.

I hope your participation in this study is a positive experience for you. If you have any questions following the interview or would like to participate in a debriefing session that can be arranged.

Once again, thank you for participating in this interview.

Appendix 12

Researcher's Aid Memoir

Interview questions:

1. **Could you please talk about your clients who intentionally self-injure?**

   (Sub-question if required:
   What are some of the recurring themes that come up more often?)

2. **What are your perceptions of moving forward in terms of self-injury?**

   (Sub-questions if required:
   Such as when your client is stuck in the process or moving towards healing?)

3. **Could you share about how such work has impacted on you as a person?**

   (Sub-questions if required:
   When your client has continued to self-harm:
   -How does this affect you in terms of self-confidence?
   -How does this affect your perception of the value of counselling?)

<u>Appendix 13 : Table 11</u> - Summary: Steps in preparing the data for analysis and the stages involved in the Constant Comparative Method (Glaser & Strauss, 1967) (Adapted from Maykut & Morehouse, 1994)

Stage	Action	Process Aim
1	Transcripts typed and photocopied using colour coded paper for each interview	Clearly written data to ease the analysis process
2	Unitizing the data (Lincoln & Guba, 1985) and coding units	Identified units of meaning. Using a range of strategies and resources (codes on transcripts, index cards, scissors, tape, marker pens)
3	Discovery Journal Discovery Sheets –Answer questions a-e: a – What are the recurring words, phrases, topics in the data? b – What are the concepts the interviewees use to capture what they say or do? c – Can you think of other concepts that capture some recurring phenomenon? d – Can you identify any emerging themes in your data, expressed as a phrase, proposition or question? e – Do you see any patterns? Focus of inquiry – write down	Identifying potentially important experiences, ideas, concepts, themes in the data. Produced an Initial Discovery Sheet (large piece of paper) Produce a focus of inquiry sheet
4	**Constant Comparative Analysis:** Inductive category coding – gather together meaning in data under categories. Will need – Prepared unitized index cards Research journal Focus of inquiry sheet Initial discovery sheet (also, markers, tape, blank index cards, large sheets of paper, scissors)	Provisional coding of categories using 'look/feel alike criteria' to discover emerging categories. Creating rules for inclusion leading to establishing subcategories, categories and propositional statements.
5	Categorizing positive and negative instances	Identifying positive statements which support the phenomenon and: Negative statements which disagree
6	Coding data cards to their categories – placing them under the appropriate category Large paper –visual wall-paper method	Refinement of categories
7	Exploration and identifying relationships and patterns across categories	AIM TO HAVE:- SEVERAL WELL-WRITTEN PROPOSITIONAL RULE STATEMENTS MANY DATA CARDS WITH EACH RULE FOR INCLUSION. OUTCOME PROPOSITION STATEMENTS:- THOSE WHICH STAND ALONE AND THOSE WHERE THERE IS A SALIENT RELATIONSHIP PRODUCE A FINAL DISCOVERY SHEET
8	Complete the final literature search Read relevant research articles Writing the various sections of the dissertation	COMPLETED THE DISSERTATION (16,000 WORDS +/- 10%)

Appendix 14 : Rules for Inclusion

- 1. The counsellor experiencing shock in response to the visual impact of the client's self-harm.
- 2. The counsellor experiencing sadness when working with clients who intentionally self-injure.
- 3. The counsellor experiencing anxiety when working with clients who intentionally self-injure.
- 4. The counsellor experiencing anger or frustration when working with clients who intentionally self-injure.
- 5. The counsellor acknowledging the client's scars without showing fear to the client.
- 6. Such work impacting on the counsellor triggering their own pain relating to their own life.
- 7. Such work having a negative, positive or no impact on the counsellor's self-confidence.
- 8. The counsellor stating there is a requirement to put aside powerful thoughts and feelings in the session in response to the client's self-harm.
- 9. Counsellors stating there is a requirement not react with panic to self-harm or suicide threat.
- 10. Counsellors experiencing anxiety due to self-harm escalating to suicide.
- 11. Such work having an idiosyncratic impact on the counsellor.
- 12. Counsellors viewing their own self-care to be essential for such work.
- 13. Counsellors having an explicit or implicit agenda for change to stop the self-harm
- 14. Counsellors viewing progression as a decrease in the level of physical damage in the client.
- 15. Counsellors viewing progression when clients begin to use replacement strategies to minimise their self-harm.
- 16. Counsellors viewing progression as the client now able to talk about and express their feelings.
- 17. Counsellors viewing progression when a client begins to gain some insight into why they self-harm.

- 18. Counsellors voicing contradictory statements in terms of the goals of therapy, `I need to accept the client's self-harm as a coping mechanism` but also has a goal of stopping the self-harm.
- 19. Counsellors perceiving external expectations (society, other professionals, family members) to help their clients to stop the self-harm.
- 20. Counsellors taking a client-focused approach involving not focusing on the self-injury or taking a more directive approach and focusing on the self harm in the session.
- 21. Counsellors communicating their views on which counselling approach they take or which is most helpful with clients who self-injure?
- 22. Counsellors voicing their opinions as to why people self-harm?
- 23. Counsellors stating there is a requirement to inform clients of the consequences of scarring.
- 24. Counsellors viewing self-harm as a coping mechanism for the client, including a legitimate or maladaptive way of coping.
- 25. Counsellors stating there is a need to respond to self-harm in the 'here and now'.

Appendix 15

Table 12 : linking units of meaning to initial group categories.

Accounting for the possibility of sub-categories belonging to more than one category (refer to key below).

Nos	Units of meaning	Group category											
		A	B	C	D	E	F	G	H	I	J	K	L
1	Impact – Shock												
2	Impact – Sadness												
3	Impact – Anxiety												
4	Impact – Anger/Frustration												
5	Acknowledging scars without showing fear												
6	Impact – own 'stuff' triggered												
7	Impact – Self-confidence affected early on in training												
8	Impact – having to put aside powerful thoughts/feelings in response to self-harm												
9	Requirement to not react with panic to self-harm/suicide threat												
10	Anxiety due to self-harm escalating to suicide												
11	Impact – idiosyncratic effect												
12	Self-care of counsellor												
13	Explicit/implicit agenda for change –to stop the self-harm												
14	Progression – decrease in level of physical damage												
15	Progression – using replacement strategies to minimise self harm												
16	Progression – Affect Regulation, now talking about their feelings												
17	Progression – Client gaining an insight into why they self-harm?												
18	Possible blocks in stopping the self-harm: contradictory stance of therapist:												

Table 12 continued

	-acceptance -goal of stopping												
19	External expectations to stop the self-harm												
20	Client-centred approach – not to focus on the self-harm												
21	Which counselling approach?												
22	Why people self-harm												
23	Consequences of scarring for client												
24	Viewing self-harm as a coping mechanism												
25	Need to respond to self-harm in the 'here and now'												

Key - Group categories:

A – Impact - The counsellor experiencing intense emotion in response to working with self-harm -shock, sadness, anxiety and anger/frustration
B – Impact – Personal impact on the counsellor's self-confidence when first working with self-harm
C – Idiosyncratic impact on the counsellor
D – Necessary requirements of the counsellor when working with self-harm.
E – Counsellor agenda for change, to stop the self-harm – explicit/implicit.
F – Progression – decrease in level of physical damage
G – Progression – client using replacement strategies to minimise self-harm
H – Progression - Affect Regulation, client now talking about their feelings
I – Progression – Client gaining an insight into why they self-harm?
J - Progression-not simply about stopping the self-harm.
K – Counsellors views on why people self-harm?
L – Counsellor perceiving self-harm as a coping mechanism

Referring to the above table, it can be seen that for the units of meaning 1,2,3 and 4 corresponding to shock, sadness, anxiety and anger/frustration experienced by the therapist are directly linked to group category A, described as 'the counsellor experiencing intense emotion in response to working with intentional self-harm'. Using the 'look/feel alike' approach, other units of meaning were linked to this group category such as 'anxiety due to self-harm escalating to suicide' (10) and 'expectations from external services to stop the self-harm' (19) contributing to the pressure on the therapist, adding to their anxiety. Other units of meaning deemed to be relevant, due to them adding to therapist anxiety included, 'possible blocks in stopping the self-harm due to contradictory messages by the counsellor' (18), 'external factors such as outside expectations to stop the self-harm' (19) and unit of meaning 22 of 'why the client self-harms'.

In terms of the 'personal impact on the counsellor's self-confidence', when first working with self-harming clients (cat. B), various units of meaning were relevant. Participants 1, 2 and 3 all experienced shock, sadness and anxiety (1,2,3) and also identified a decrease in their self-confidence, so these units of meaning appeared applicable due to a possible link. For

one participant who identified a decrease in self-confidence initially, he also described how his 'own stuff' was triggered (6). Other possible links, relating to a decrease in the therapist's self-confidence included, 'fear of self-harm escalating to suicide' (10), anxiety due to pressure from the 'expectations from external services to stop the self-harm' (19) and 'pressure on the counsellor in terms of which is the most appropriate counselling approach' (21) all deemed possible factors in terms of affecting therapist self-confidence. For the 'idiosyncratic impact on the counsellor' (group cat. C), this category appeared to stand alone.

There were various units of meaning which related to group category D identified as, 'there are necessary requirements of the counsellor when working with self-harm', including, 'acknowledging scars without showing fear' (5), 'having to put aside powerful thoughts and feelings in response to self-harm' (8) and 'not reacting with panic to self-harm or suicide threat' (9). Other relevant units included, 'self-care of the counsellor' (12), 'having a client-centred approach' in not focusing on the self-harm (20) and communicating the consequences of scarring to the client'(23). Finally, units of meaning such as 'viewing self-harm as a coping mechanism' (24) and 'the need of responding to self-harm in the here and now' (25) were also applicable.

In terms of 'the counsellor having either an explicit or implicit agenda for change to stop the self-harm' (cat. E), there were other relevant, over-lapping units. Progression viewed as there being 'a decrease in the level of physical damage' (14) had a direct relevance in terms of an agenda for change. Similarly, 'the client now using replacement strategies to minimise the self-harm' (15) and' communicating the consequences of scarring to the client' (23) were relevant in terms of having an agenda to stop the self-harm.

Regarding the group category of progression viewed as 'decreasing the level of physical damage' (cat. F), related units included 'having an agenda for change' (13), 'the client now using strategies to minimise the self-harm' (15), 'external services having the expectation to stop the self-harm' (19), 'which counselling approach' being the most appropriate (21)in terms of reducing damage and communicating 'the consequences of scarring' (23) could all be factors involved in reducing the physical damage.

For the group category of 'the client using replacement strategies (e.g. clenching dry ice) to minimise self-harm' (cat. G), there were also overlapping units. 'Therapist agenda for change' (13) was deemed relevant here, along with 'views on progression incorporating a decrease in the level of physical damage' (14), 'expectations of external service to stop the self-harm' (19), 'which counselling approach' (21) and 'consequences of scarring' (23), all having a possible impact on whether the client begins to use such strategies.

Group category H was identified as 'progression viewed as being linked to affect regulation' with the client now able to express and talk about their feelings and again certain units are relevant here. These included, the counsellor 'acknowledging the client's scars without showing fear' (5), 'the therapist having to put aside powerful feelings (8) and 'not to react with panic' (9) which would likely influence this client process in terms of affect regulation. In particular, unit 20 identified as the therapist having 'a client-centred approach' using the 'look/feel alike' approach was relevant here. The rationale being that the client would be setting the agenda and possibly focusing on feelings rather than being directed by the therapist to focus on the act of self-harm. Similarly, 'viewing self-harm as a coping mechanism' (24) was relevant and 'the counselling approach' (21) was also applicable as a specific approach may be more helpful to the client when talking about feelings.

With regards to progression being perceived as the client gaining an insight into why they self-harm' (cat.I), other units such as 'which counselling approach' (21), 'why a person self-

harms' (22) and 'self-harm being viewed as a coping mechanism' (24) were all relevant as they would likely contribute to the client gaining insight.
Group category of 'progression viewed as not simply about stopping the self-injury' (cat. J) there were other relevant units. For example, 'affect regulation (16) and 'the client gaining insight' (17) were directly relevant as these involved the client focusing on other aspects rather than just aiming to stop the self-harm. Others, such as having 'a client-centred approach' (20) involving following the client's agenda and it being 'viewed as a coping mechanism' (24) were also applicable, giving other aspects to focus on in therapy.

For the final 2 group categories of, 'why people self-harm' (cat.K) and 'viewing it as a coping mechanism' (cat. L), appeared to stand alone with no real overlaps of units of meaning.

Appendix 16

Informed consent form

M.A. Counselling Studies Research
Consent Form
Audio Recording of Interview

I .....hereby give consent for the details of a written transcript based on an audio recorded interview with me and.....to be used in preparation and as part of a research dissertation for the M.A. in Counselling Studies at University of Chester. I understand that my identity will remain anonymous and that all personally identifiable information will remain confidential and separate from the research data. I further understand that the transcript may be seen by Counselling Tutors and the External Examiner for the purpose of assessment and moderation. I also understand that all these people are bound by the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice and Psychotherapy.

I understand that I will have access to the transcribed material should I wish to and would be able to delete or amend any part of it. I am aware that I can stop the interview at any point, or ultimately withdraw the interview before the publication of the dissertation. Upon completion of the research the audiotape will be offered to me, or, by prior agreement with me, destroyed.

Excerpts from the transcript will be included in the dissertation. Copies of the dissertation will be held in the University of Chester Library and the Department of Social and Communication Studies Resource Room.

Without my further consent some of the material may be used for publication and/or presentations at conferences and seminars. Every effort will be made to ensure complete anonymity.

Finally I believe I have been given sufficient information about the nature of this research, including any possible risks, to give my informed consent to participate.

Signed (Participant) .....

Date .....

Signed Researcher) .....

Date .....

Appendix 17: Image a - Colour coded transcripts

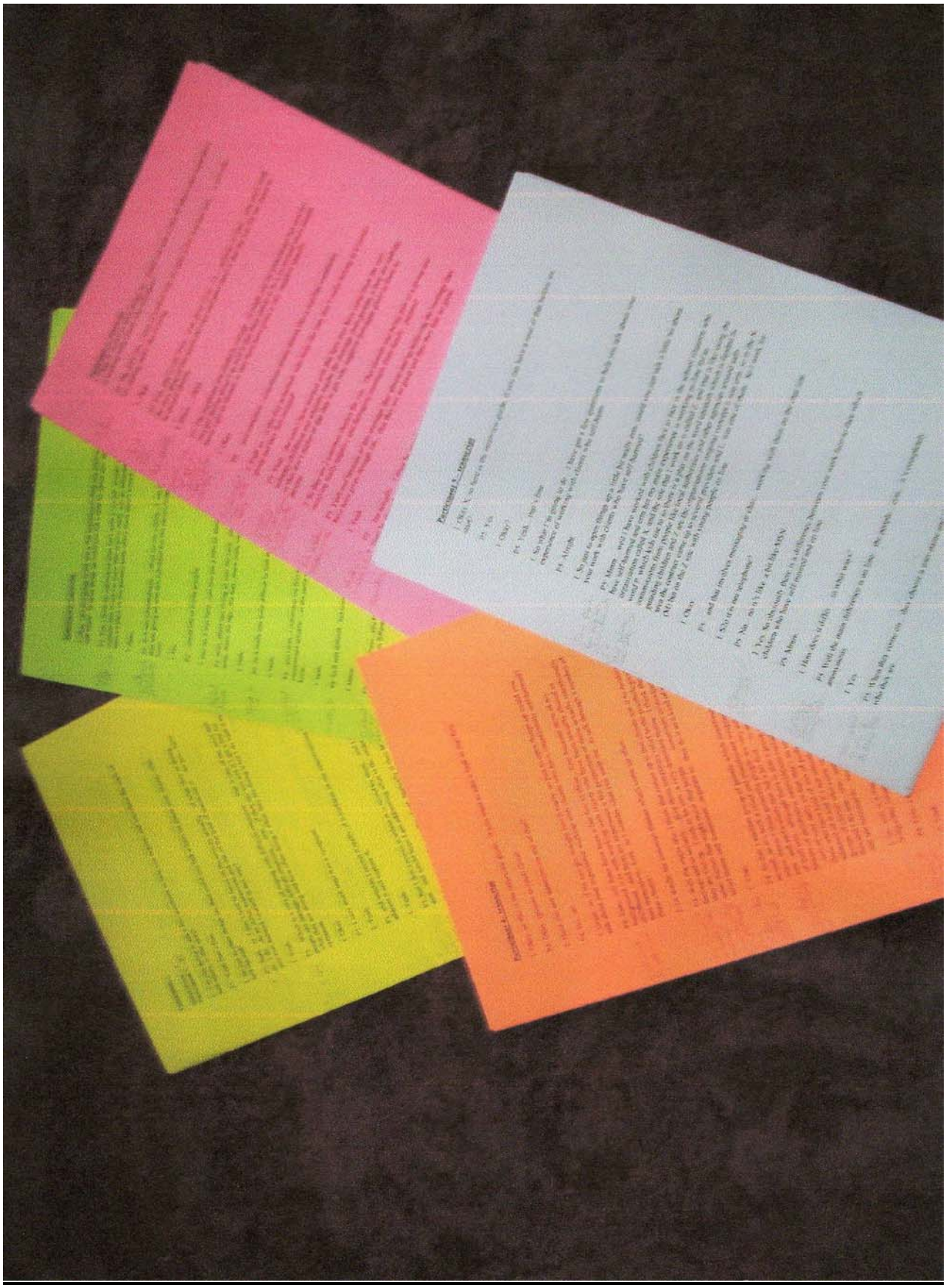


Image b - Unitized data, smaller units of meaning cut and pasted onto

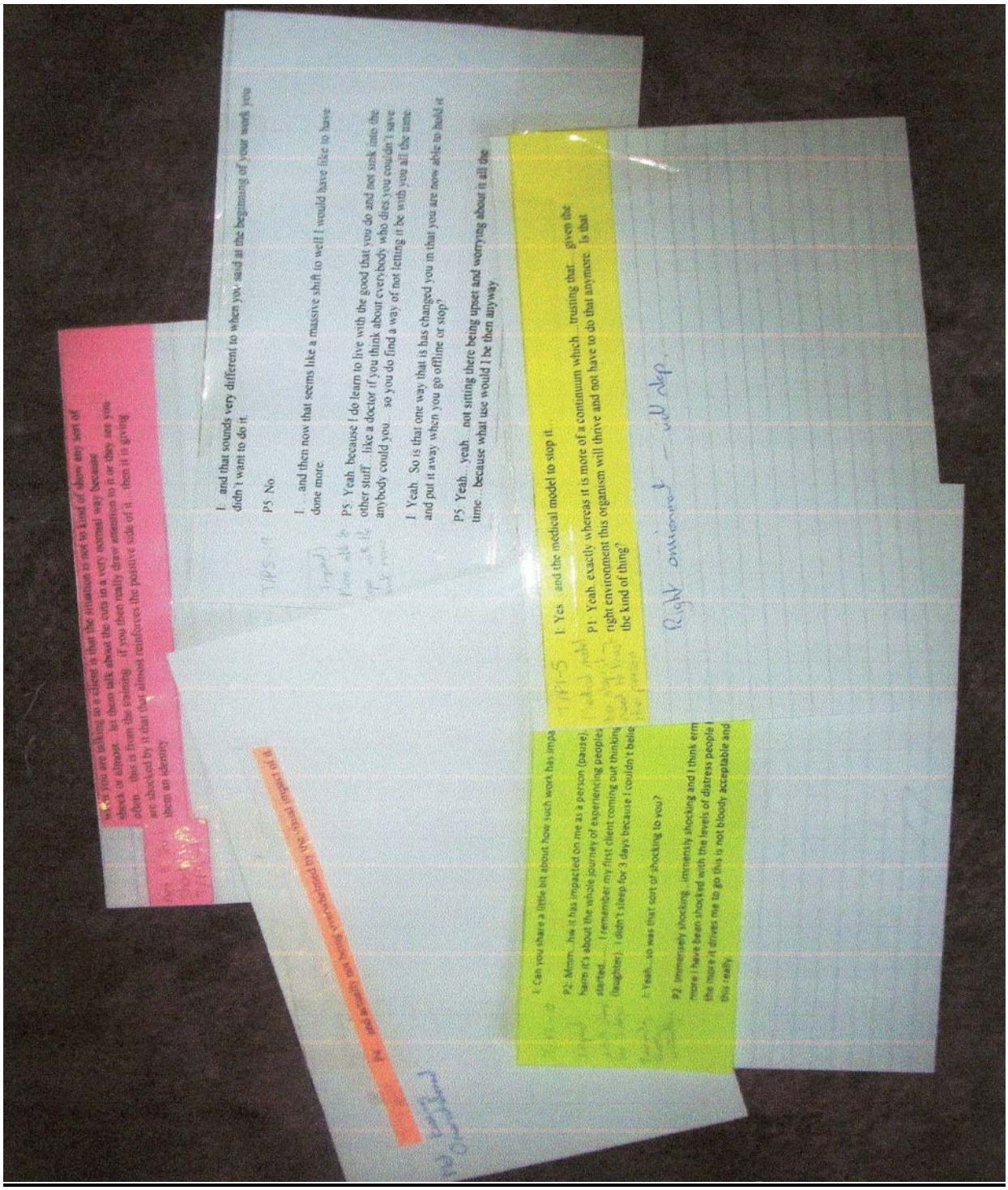
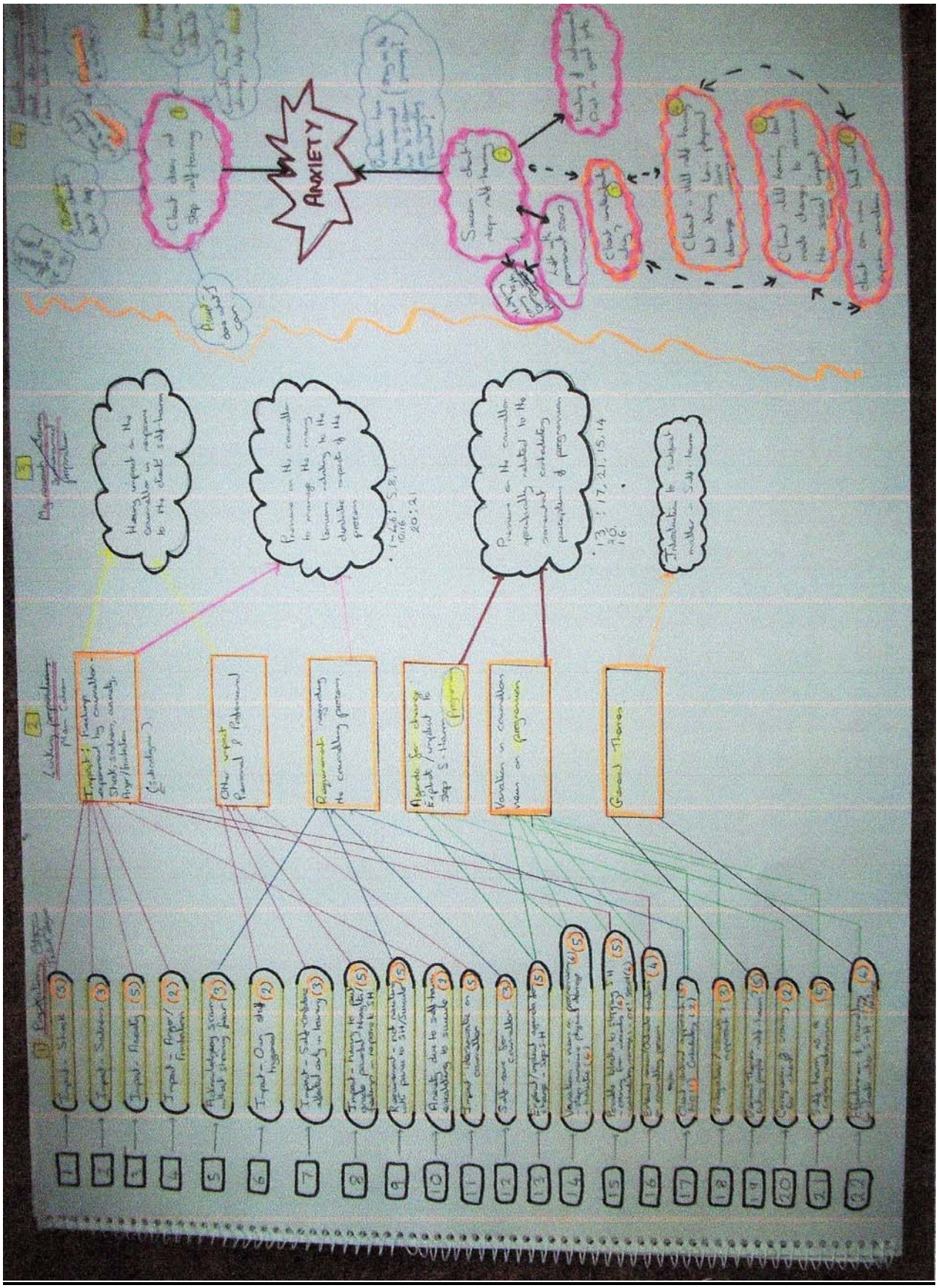


Image c – placing units of meaning into categories using rules for inclusion)

Image d - Final Discovery Sheet



Appendix 18 – Journal

Date	Comment
7th Sept 09	I now have a focus of enquiry, a method of collecting data (interviews) and a method of analysis (Constant Comparison Analysis). I have also identified the questions for the interview and at last I feel I have began my research. For the last few months I have been thinking about how to begin my research and now it feels as if I am finally doing something, rather than just thinking and planning.
9th Sept 09	I have been thinking about my interview approach and have come up with some possible prompts if the participant gets stuck. I do not want to lead the participant or leave them feeling anxious if they do not know where to start talking. This is a difficult balance to get, but I have kept my prompt questions as open as possible.
29th Sept 09	I have completed the first interview. Feeling relieved as it seem to go quite well without any hiccups. The participant talked quite freely and I was encouraged by her openness to share her experience. I actually enjoyed the interview process and I am pleased that I have actually begun my research.
18th Sept 09	The second interview is now completed and it feels good to be actually getting on with the research. The interview appeared to go well and once again the participant had no trouble talking. The participant shared just how helpful it was to share her thoughts and feelings on working with clients who self-harm. I just need to type up the transcript which is time consuming.
3rd Oct 09	Interviewed a participant who saw my advert in a workshop. The interview went well and the participant talked openly and very succinctly. I am becoming aware of the variety in styles of communication with some participants talking in a very concise way and others using more descriptive speech, having the effect of transcripts of various lengths. This participant said she found the interview helpful and found the experience a positive one. I felt happy with how it went and am looking forward to typing the transcript and having 3 completed.
10th Oct 09	Interviewed another participant. Again the interview seemed to go well and the participant talked easily and openly. I felt relaxed during the interview and am glad I only have one more participant to include.
27th Oct 09	Interviewed my last participant today. I feel relieved that I now have the data for my research and can at last get on with the analysis. My next step is to transcribe this last interview before beginning the analysis.
29th Dec 09	I feel relieved now that all the interviews are completed and the audio data transcribed. This has been very time-consuming but well worth it as I feel I have really emersed myself in the data. For every participant there is something relating to the impact on

	them and views of progression so that is reassuring.
30th Dec 09	I am feeling a little inpatient to begin working on my analysis but my workload is getting in the way at present. I will be relieved to begin.
8th Jan 10	I feel I am becoming a little more organised. I have created the table of participant characteristics and have collected the resources for step 1 of the analysis. I am feeling more positive about beginning the analysis. I have now photocopied the transcripts on to colour coded paper to begin unitizing the data but it does seem a little overwhelming.
11th Jan 10	Today I began to unitize the data. I finished doing this for participant 1 but I did not realise how time consuming this would be. There seems to be a long way to go.
15th Jan 10	I am feeling more positive following my supervision session. I feel I am on track and I just need to be persistent and patient, taking it one step at a time. I am continuing to unitize the data from the transcripts and avoiding focusing on the end of the process.
16th Jan 10	Today, I feel relieved as I have completed unitizing the data from the 5 transcripts (coding and sectioning them off via a pen-line). However, there are a lot of small units of meaning and I have no idea of how long the analysis is going to take.
22nd Jan 10	Today, I completed a discovery sheet by reflecting on the small units of meaning. The positive side is, I seem to have useful data on impact on the therapist and on progression, so I am feeling encouraged despite the long way ahead.
29th Jan 10	Today I began cutting apart the unitized meanings and taping them onto separate 5" X 8" index cards. Managed to complete half of transcript P3. Again, this is very time consuming and I am stuck between feeling positive as I am becoming really emersed in the data but feeling inpatient as to the long process ahead of me.
30th Jan 10	Today I completed cutting apart the unitized meanings from P3 – I now have 84 index cards with separate units of meaning – from only 1 participant!! 4 transcripts to go. Feeling a little overwhelmed now as I wish I had more time to dedicate to the process. At this point, I am wondering how on earth I can compare all this data?
2nd Feb 10	I have now completed 2 more transcripts by cutting and sticking on to index cards. I only have 2 more transcripts to go then I can move on to the next step in the analysis.
19th Feb 10	Today, I completed unitizing the data and sticking them onto individual cards. I feel very happy now I am at this stage. Quite surprised at the number of smaller units of meaning. Participant 5 has the largest number – 98 units of meaning!!! This has been a very time consuming exercise and I am relieved this part is now complete.
20th Feb 10	I have now moved on to the next step of categorising the unitized index cards into groups and pasting them on to large flip-chart size paper. I have also a focus of inquiry sheet and a discovery

	sheet (recording significant words, concepts and themes).
26th Feb 10	Completed more Category sheets and it feels like the analysis is beginning to come together. This research process is good for me as it is forcing me to split the process down into small steps. I dislike procrastination and like to meet targets and goals but this process is developing step by step with me having no set end point but which will become clear once I have gone further into the analysis and the write up.
27th Feb 10	Continuing with the process. As this proceeds, I am beginning to think about the link between Impact on the counsellor and progression. I am beginning to make some sense of all this rich data.
1st March 10	I wrote out a new discovery sheet today, mostly linking progression to the impact on the counsellor. I now have 8 rules for inclusion with associated units of meaning and things are becoming a little clearer.
20th March 10	I now have 18 rules for inclusion. I feel I have categorised the most useful units of meanings in my study and am now just going through the motions in terms of thoroughness. I am continuing categorising the rest of the data cards. This is quite time consuming and I will be glad when this is completed.
29th March 10	I have been through all the cards now. I have come up with 4 more categories and placed all cards into them. I have now completed searching to see if the units of meaning belong to one or more of the categories and have photocopied and inserted the ones who did. I am relieved that this step is completed and now I can move on to the next stage.
30th March 10	I have been checking to see if some categories overlap and exploring the relationship and patterns across the categories. I am feeling more confident with this analysis process as it is beginning to make sense.
1st April 10	I have been continuing to refine the categories, making sure any overlaps are included. I have been constructed sheets relating to each category and reflecting and refining.
30th April 10	I have now constructed a table of findings linking sub-categories (smaller units of meaning) to categories (rules for inclusion). I am really enjoying this part of the analysis as I can now see emerging outcomes for my study.
1st May 10	Today, I took digital photographs of each stage of the analysis to include in the appendix of my dissertation. I like to be thorough even though this is not a requirement but it gives a visual representation of each step in the process.
7th May 10	My mind is continuing to process the research. Today I constructed a table of categories linked to participants' comments. This appears to be leading to more clarity in terms of outcomes.
28th May 10	I have now come up with 4 proposition statements. It feels good to be at this stage. I am now anticipating writing up my dissertation.

29th May 10	I now have more time to dedicate to writing up my dissertation and completing the final literature review. I am really enjoying this step in the process and finding appropriate existing research to add weight to the points I am making.
21st June 10	Over the last 4 weeks I have been active in terms of reading, writing the findings section and writing the discussion of my dissertation. I am now nearing the stage of completion, with just the abstract to write and feeling a real sense of achievement.

Appendix 19

Table 13 - Participants comments related to categories.

Category	Participant	Comment
1.The counsellor experiencing intense emotion:		
• **Shock**	1	"*..it is like an impact like a thud or a thump or....I do find it shocking".*
	2	*" I remember my first experience of looking at the person and being quite mesmerised actually....at the same time thinking Oh my god..what the hell has gone on here?.*
		"I didn't sleep for three days...immensley shocking..immensley shocking...".
	3	*"Yeah..and it was oh my god, can I really do this?.*
		"I remember the shock factor...but I was more shocked at myself thinking I don't know what to do with it".
	4	*"Yes..I do get shocked sometimes and I do feel upset sometimes especially if somebody is self-harming in a very visual way".*
		"..the times when I have been shocked....been out of the ordinary....somebody turning up who has just self-harmed and there is blood all over them"
• **Sadness**	1	*"I feel a lot of grief when it's being talked about. Can feel quite sad, a sadness about it*".
	3	*"I would feel generally sad that somebody wants to hurt themselves*".
		"*It was about that self-awareness of knowing whether this is my client's sadness or is it mine".*
	5	"*You know it's very sad...it's very hard with young people..it's heartbreaking*".
		"*I feel saddened by it..the sadness does stay with me*".
		"*I feel like a sadness with me...but I can't always leave it behind*".
• **Anxiety**	1	*"..initially there was a bit of all at sea..Yeah below the water...Yeah..I'd feel overwhelmed.".*
	2	"*So it was tremendously..I think for me initially..it was hard to have a look and see the damage that was going on..".*
	3	"*..but even now I always wonder what happened..if she carried on the way she was going...*
		"*..and the other two clients where in my early days of training when I did feel out of my depth*".
		"I think it was more about feeling I'd cocked it up at the time, I've never dealt with this".
		"*I would go to supervision and say, what I am really feeling is I wanted you to stop...please stop..*".
	4	"*I tend to see that as oh my god you are in a lot of pain here..and that does have an impact..it has a similar impact on me..I mean there is always a risk of secondary traumatisation*".

	5	"*...or if somebody pulls a knife out of a bag and says I am going to kill myself right here right now..those are the things which have a much more immediate impact and leave me a bit wobbly*". "*My main worry with somebody who keeps self-injuring would be that it gets worse and the risk of death or accidental death or yeh know serious physical problems is actually increasing the longer people do* it...for it to slip into suicide territory". "*..if they are talking about slashing their wrists...and you don't know who they are(telephone counselling) there is nothing you can do..so it's not really safe*". "*It was very hard at first...I was always wanting not to do it...it's heartbreaking and feeling the way they feel...it felt very insecure and not very safe..I felt a bit helpless at times*". "*..it comes out of absolute terror...having to live with that...I couldn't live with the responsibility of I didn't do everything that I could do...but who's to say that I couldn't make a mistake and that is around*".
• **Anger/frustration**	2	*"..the psychiatrist said there must be something wrong with you and he put her on ECT twice a week for 15 months because he said there was something wrong as she wasn't self-harming with me...I was actually livid".* *"Yes...it pisses me off...pisses me off...because I hear so much.....people going up to A&E and don't get any anaesthetic..they are treated terribly".*
	4	*"I think it would affect my patience* (when client does not stop) *but not necessarily my self-confidence...I'd probably feel impatient*".
• **On counsellor's self-confidence when first working with self-harm**	1	*"..when I first began practicing, I was really alarmed by self-harm...".*
	2	*"self-confidence..oh massively improved...now an openness to accept and just be as you find it".*
	3	*"It did I think (affect my self-confidence) when I first saw a client with self-harm and I referred her".*
• **Does not affect the counsellors self-confidence**	4	*"I've worked long and hard and get to a place where I don't lose my confidence....so I'm not willing to give that up.*
	5	*"Don't think so....no...I don't see it that way..I just see it as the kids are in pain and i'm there for them"*
• **Idiosyncratic impact on the counsellor**	2	*"I think for me my god ..I think I've had a very bloody happy like thank you very much".* "*With regards to this...is horrendous for people and I want to do something..it's not a fight it's almost a driver*".
	3	*"I was able to work out that it was tapping into..some childhood pain in me*"*...in a positive way I think it really helped me with ...reassured me of my acceptance of people generally that is the biggest positive to come out of it".*
2.Necessary requirements of the counsellor when working with self-harm:	1	"*...and to be a robust enough container that I don't*

• **To be a robust enough container, avoid showing shock, not get overwhelmed and not react with panic**	3 4 5	*get overwhelmed. I can be with them without getting overwhelmed and help them".* *"people are very alarmed by it..it is linked too closely with suicide I think..can stir up a lot of panic...can jump to stop it"* *"..is not to show any sort of shock".* *"..because I didn't kind of react in any way...I just let her tell her story".* *"..not to be dramatic...not to be terrified".* *"..in the early days I did feel out of my depth".* *"the one message which really hit me was about not reacting to it..almost let them show you".* *"..and actually not being overwhelmed by it".* *"...if they are suicidal...promise me...you can do that in a jokey way..but a way of saying wait till next week"(with young clients).*
• **<u>Not</u> to focus on the act of self-harm**	1 2 3 4	*"I don't tend to focus on the activity actually".* *"..when people are coming in self-harming, I don't look at that..but to focus on what has got them to that point".* *"...to show...kind of show interest in the person and not the cuts".* *"I think I try not to focus on the frequency and the act of self-harm in itself because if that starts to happen then the self-harm becomes the client rather than the client".*
• **<u>Need</u> to focus on the self-harm**	2 5	*"...if I am concerned they are harming themselves ....it is not abut me shying away from that in any way" .* "*My experience is checking out the safety of it".* *"I try to talk about that...when did it start....".* *"There is always going to be a safety issue. It would feel like collusion letting them talk about it without...to check out whether the client is suicidal or can get immediate care".*
• **Invest in self-care of the counsellor**	1 3 4	*"...getting a really good supervisor".* *"..that's is why the value of supervision is so important".* *"..so I've learnt coping methods to deal with it...it can be a visualisation...".* *"..need a good support system in place....have a very good supervisor".*
• **Need to give advice on how to care for wounds**	1 2 4 5	*"I do check that whether people are looking after themselves...have they got antiseptic...".* *"...saying...it is far better to be safe and do it than it is to use dirty blades and get other infections".* *"..to be pragmatic about the after-care...taking care of yourself after you have self-harmed".* *"..let's check how you are doing it are you...how dangerous is it....can you make sure it's clean...".*
• **Communicate the consequences of scarring**	3 4	*"discussing..will never get to the point where somebody is never going to see them"(scars)* *".informing the client..scarring..if it is visible, is a constant reminder..is a social impact"*

3-Counsellor having an agenda for change to stop the self-harm • **Explicit agenda**	2	"*..let's work towards you stopping the self-harming...it's okay and you deserve better...you are starting to respect yourself*". "*..if this isn't stopping I want to know why...what is it that is going on that you are not able to take responsibility here and start to unpack this at a deeper level*".
	5	"*Helping them to take the next step to get support to help them find different coping mechanisms before they stop. It doesn't mean I don't talk to them about stopping...let's look at some of the strategies..what about trying one until next week?".* "*..but can be difficult to change...with Borderline Personality Disorder..."*
• **Implicit agenda**	1	"*..trusting that...given the right environment this organism will thrive and not have to do that anymore".*
	3	*"The congruent bit of me would be sad as I would wish for them to have a better way of coping...that had no risk to their health*". "*I would go to supervision and say, what I am really feeling is I wanted you to stop..please stop*".
	4	"*I wouldn't just say...oh well that's fine...you just keep cutting and that's absolutely fine as I think that then gives a message that I don't particularly care".* "*I think for me...people come to see me because they want to change*". "*..as a long term coping strategy it tends to peg people into a corner...erm..where the cost is greater than the benefits*". "*..and I don't want to be trapped in a situation where..nothing ever changes...and I wouldn't want that for the client either*". "*..and I do have an agenda there because I think that you know part of it is an act of trying to nourish yourself...you're so desparate..you need to do something to make yourself better by cutting yourself*".
4.Progression • **decrease in the level of physical damage**	1	*if they do mention self-harm, I'll ask well is it changing in nature or in frequency or is it raised...I'll ask and it maybe that there is some report that it is not as bad. Like the cutting is not so deep*".
	2	"*So I suppose it's a bit of a gage for me actually...is it pulling back...in terms of where the process is going...self-harm is an easy signal because it is there*".
	5	"*...and they might come up and say, you know what, it is actually 6 weeks, 14 days and 3 hours since I last did anything to myself*".
• **The client using replacement strategies to minimise the self-harm**	4	"*People came up with very idiosyncratic ways of moving away from self-harm. It doesn't have to be cutting you..it could be cutting anything...a box of candles...she would rip those to shreads".* "*..and maybe not minimise the self-harm but*

		minimise the impact of self-harm..because sometimes people don't stop".
	5	"*Yeah, stay with them and help them get the right help....but quite often they say to you, what do...what have other* people tried?..so well you can say...the usual...elastic bands, dry-ice, ice-cubes".
• **Affect regulation-client now talking about feelings**	1	*I think it is about not having developed affect regulation....then moving to talking about discreet emotions is a good indicator*".
	2	"*...once she got into it and explored it....she'd just sob and sob and sob and sob...but my goodness it was just so cathartic for her*".
	4	(Changing from) "*... use it to moderate their feelings*".
	5	Now feeling the pain and moving away from, w*hen they feel the pain...they don't feel the emotional pain*".
• **Clients gaining an insight into why they self-harm?**	3	"*..the first step I would see..moving forward...is them gaining an insight into what it is all about rather than just doing it*".
		"*When they start to see it in that way, choosing to stop it then..so that is one way forward*".
	5	"*They slowly change from being...seeing it as positive to acknowledge it as maybe not quite as positive as they first thought. They begin to see it completely different to how they* did do".
• **Not simply about stopping the self-harm**	1	*"I wouldn't be whipping away somebody's comforting mechanism. I would hope that it would happen little by little".*
	2	"*..if you've got a crutch there and there ae different ways I can deal with this...I can kick the crutch from underneath you then you're going to fall down...and you have to pick yourself up or I actually work to the point where you throw your own crutch away".*
	3	"*I don't think the step forward is to just stop. For me..the step forward is that self-understanding that says oh well now I can grasp why I'm doing it...what I am doing*".
	4	"*.but there are ways of minimising at least the social impact of it..cutting in a place which is less risky in terms of physical damage..such as away from tendons*".
		"*I think a lot of the work about self-harm is unpicking viscous circles from the past*".
	5	*"...encourage them to talk...but not to give up self-harm immediately...not being judgemental or saying...just don't do it because..that's not really going to help them".*
5.-Counsellors perceptions on why people self-harm?		
• **As a reaction to overwhelming feelings stemming from personal experience/history**	1	"*It's usually about desperation...usually despair is a very strong word..overwhelmed...not okay, feeling definitely not okay...feeling very bad...kind of wanting some peace*".
	2	"*...probably generally abuse driven actually*".

	3	"*..about.. well..it's...around when people haven't got an identity or they have been given a very negative identity*". "*When she was cutting like it was almost like she could feel something, she had felt so devoid of feeling..she felt alive by doing it*". "*Suddenly she wasn't invisible because people were noticing and talking about her even the fact that they were shocked and horrified...gave her a sense of identity".*
	4	"*Client's use it to moderate their feelings...sometimes they do it as a kind of punishment...in my experience it is part of a bigger picture and as a result of bigger problems*".
	5	"*It's ...a lot..sexual abuse is common..in their history. Bullying is a big factor, family issues, Border-line Personality Disorder...sometimes a deprived background..yeah so a lot of different factors really..the self-hared, self-disgust and dislike.* "*Not being worthy...some of it is...look how bad things are...this is a bad way of doing it because I am a bad person...I'm hurting*". "*...but it is like their own hug so they don't see it as a negative they see their cutting as very positive...because it makes them feel better emotionally...like making the physical pain take away the emotional pain*".
• **Perceiving self-harm as a coping mechanism**	1	"*I believe it is a way of coping*".
	2	"*..if this is the way you are coping at this moment in time...then be safe..that's absolutely fine*". "*...but there's more...a lot more going on really*".
	3	"*..so a coping mechanism which has worked for years and years....sometimes for some people it is a coping method...even if it isn't working anymore...almost still use it but to carry on and make it work*".
	4	*"...if that is the only coping mechanism people have it gives them relief then that in itself is something".* *"...what started off as a coping mechanism can now be more like hooking them in and keeping them there...something they can't get out of any more*".
	5	"*It's working for you for now...it's okay, but let's check how you are doing it...how dangerous is it...".* (Do you see it as a kind of coping mechanism?) – *"Yes, very much so*"(p8)